



Trauma-Informed Care

Heather Forkey, MD, FAAP,^a Moira Szilagyi, MD, PhD, FAAP,^b Erin T. Kelly, MD, FAAP, FACP,^c James Duffee, MD, MPH, FAAP,^d
THE COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, COUNCIL ON COMMUNITY PEDIATRICS, COUNCIL ON CHILD ABUSE
AND NEGLECT, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH

Most children will experience some type of trauma during childhood, and many children suffer from significant adversities. Research in genetics, neuroscience, and epidemiology all provide evidence that these experiences have effects at the molecular, cellular, and organ level, with consequences on physical, emotional, developmental, and behavioral health across the life span. Trauma-informed care translates that science to inform and improve pediatric care and outcomes. To practically address trauma and promote resilience, pediatric clinicians need tools to assess childhood trauma and adversity experiences as well as practical guidance, resources, and interventions. In this clinical report, we summarize current, practical advice for rendering trauma-informed care across varied medical settings.

INTRODUCTION

Experiences in childhood, both positive and negative, have a significant effect on subsequent health, mental health, and developmental trajectories. For many children and adolescents, traumatic experiences are all too common. Almost one-half of American children, or 34 million younger than 18 years, have faced at least 1 potentially traumatic early childhood experience.¹⁻⁷ Such traumas may include those originating outside the home, such as community violence, natural disasters, unintentional injuries, terrorism, immigrant or refugee traumas (including detention, discrimination,^{6,8,9} or racism), and/or those involving the caregiving relationship, such as intimate partner violence, parental substance use, parental mental illness, caregiver death, separation from a caregiver, neglect, or abuse, originally defined as adverse childhood experiences (ACEs).¹⁰ For many children, medical events, such as injury, medical procedures, and/or invasive medical treatments, can be traumatic. Given the robust science explaining the physiologic consequences of accumulated trauma experiences on the brain and body,¹¹⁻¹⁴ there have been calls for pediatric clinicians to address childhood trauma and child traumatic stress.^{10,14-16} However,

abstract

^aDepartment of Pediatrics, University of Massachusetts, Worcester, Massachusetts; ^bDivisions of General and Developmental-Behavioral Pediatrics, Department of Pediatrics, University of California, Los Angeles, Los Angeles, California; ^cAmbulatory Health Services, Philadelphia Department of Public Health, Philadelphia, Pennsylvania; and ^dDepartments of Pediatrics and Psychiatry, Boonshoft School of Medicine, Wright State University, Dayton, Ohio

Drs Forkey, Szilagyi, Kelly, and Duffee were equally responsible for conceptualizing, writing, and revising the manuscript and considering input from all reviewers and the Board of Directors; and all authors approved the final manuscript as submitted.

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

Clinical reports from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, clinical reports from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

DOI: <https://doi.org/10.1542/peds.2021-052580>

Address correspondence to Heather Forkey, MD. E-mail: heather.forkey@umassmemorial.org

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

To cite: Forkey H, Szilagyi M, Kelly ET, et al. AAP COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, COUNCIL ON COMMUNITY PEDIATRICS, COUNCIL ON CHILD ABUSE AND NEGLECT, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH. Trauma-Informed Care. *Pediatrics*. 2021;148(2):e2021052580

practical guidance about how to consider, address, and operationalize this care, although necessary, has been insufficient.

Pediatric clinicians are on the front lines of caring for children and adolescents and, thus, have the greatest potential for early identification of and response to childhood trauma. Data indicate that, although pediatric providers intuitively understand the negative effects of trauma, they report a lack of knowledge, time, and resources as major barriers to providing trauma-informed care (TIC).^{5,6} Yet, experts believe that the complete assessment of child and adolescent behavioral, developmental, emotional, and physical health requires consideration of trauma as part of the differential diagnosis to improve diagnostic accuracy and appropriateness of care.^{17,18}

TIC is defined by the National Child Traumatic Stress Network as medical care in which all parties involved assess, recognize, and respond to the effects of traumatic stress on children, caregivers, and health care providers. This includes attention to secondary traumatic stress (STS), the emotional strain that results when an individual hears about the first-hand trauma experiences of another. In the clinical setting, TIC includes the prevention, identification, and assessment of trauma, response to trauma, and recovery from trauma as a focus of all

services. TIC can be conceptualized in a public health stratification, as summarized in Table 1:

- primary prevention of trauma and promotion of resilience;
- secondary prevention and intervention for those exposed to potentially traumatic experiences, including caregivers, siblings, guardians, and health care workers; and
- tertiary care for children who display symptoms related to traumatic experiences.

This clinical report and the accompanying policy statement¹⁹ address secondary prevention and intervention: practical strategies for identifying children at risk for trauma and/or experiencing trauma symptoms. “Children,” unless otherwise specified, refers to youth from birth to 21 years of age. These clinical strategies and skills include the following^{16,20}:

- knowledge about trauma and its potential lifelong effects;
- support for the caregiver-child relationship to build resilience and prevent traumatic stress reactions;
- screening for trauma history and symptoms;
- recognition of cultural context of trauma experiences, response, and recovery;
- anticipatory guidance for families and health care workers;
- avoidance of retraumatization;

- processes for referral to counseling with evidence-based therapies when indicated; and
- attention to the prevention and treatment of STS and associated sequelae.

Pediatricians have a powerful voice and reach that could promote the policies and procedures necessary to transform pediatric health care into a TIC system. This guidance for pediatric clinicians is organized around 5 strategies for implementation to become trauma informed: awareness, readiness, detection and assessment, management, and integration. The companion policy statement¹⁹ outlines broad recommendations for implementing TIC in child health systems.

AWARENESS

Pediatric clinicians can promote resilience, identify adversity and trauma, and ameliorate the effects of adversity in their work with children and families. Although the epidemiology and physiology of trauma have been explored in the literature,^{9,12,13,21,22} few concepts have been translated into the provision of practical TIC in pediatric settings.^{6,16,23} Awareness of the science and epidemiology of trauma provides the scientific grounding for the practices of TIC.

TABLE 1 Range of Trauma Experiences, Symptoms, and Response

Potentially Traumatic Experiences	Trauma Symptoms (Table 5)	Office Response
None	None to some	Primary prevention: anticipatory guidance; resilience promotion
Single-incident or minor trauma	None or latent or mild	Secondary prevention: anticipatory guidance; resilience promotion; trauma-informed guidance; close monitoring; screen for trauma history and symptoms
Major event or cumulative	Mild to moderate	Secondary and tertiary prevention: anticipatory guidance; resilience promotion; psychoeducation; trauma-informed guidance, close monitoring, and follow-up; possible referrals to community services, mental health
Major event or cumulative	Moderate to severe	Tertiary prevention and treatment: anticipatory guidance; resilience promotion; psychoeducation; trauma-informed guidance, close monitoring, and follow-up; avoidance of retraumatization; referrals to community services; referral to evidence-based and evidence-informed trauma mental health services

Adapted from Forkey H, Griffin J, Szilagyi M. *Childhood Trauma and Resilience: A Practical Guide*. Itasca, IL: American Academy of Pediatrics; 2021.

Safe, Stable, and Nurturing Relationships

The most fundamental adaptational mechanism for any child is a secure relationship with a safe, stable, nurturing adult who is continuous over time in the child's life.²⁴ This is usually the child's parent or caregiver but can involve extended family and biological or fictive kin. It is in the protective context of this secure relationship that the child develops the varied resilience skills that will prevent or ameliorate the effects of cumulative adversities. The nurturing caregiver protects the child from harm, mediates the world for the child, and helps the child to develop the adaptive skills to

manage stressful experiences. Physiology, in addition to psychology, is affected by protective relationships.^{14,25-27}

Toxic Stress and Trauma

All children experience some stress and adversity at some point in life, but when it is managed within the context of these nurturing relationships, such events can be weathered and even used for growth. Adverse events that lead to the frequent or prolonged activation of the stress response (see Fig 1) in the relative absence of protective relationships has been termed "toxic stress" in the pediatric literature.¹⁴ Toxic stress responses result from

events that may be long lasting, severe in intensity, or frequent in occurrence. The available caregiver support is insufficient to turn off the body's stress response. It is critical to note that the toxic stress response has 2 components: the significant stressors and the relative insufficiency of protective relationships. In sum, there is a marked imbalance between stressors and protective factors.²⁸

Toxic stress responses can result in potentially long-lasting or lifelong impairments in physical and mental health through biological processes that embed developmental, neurologic, epigenetic, and immunologic

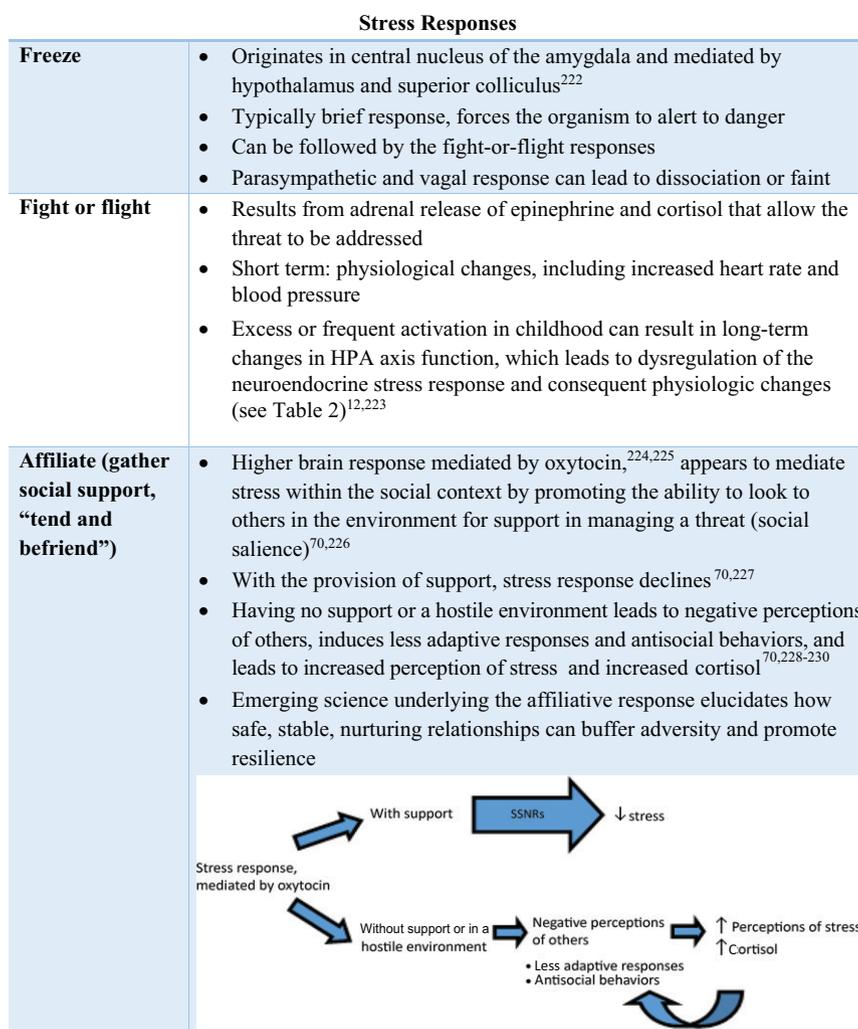


FIGURE 1 Stress responses. HPA, hypothalamic-pituitary-adrenal.

TABLE 2 Physiologic Effects of Trauma in Children

Area	Impact	Specifics	Implications and Associations
Brain connectivity ⁸⁵	Cortisol acts on rapidly developing brain structures	Amygdala overactive; hippocampus underactive; prefrontal cortex not accessible	Preliminary association with more severe clinical course in major depressive disorder
Epigenetic changes ²¹	Methylation patterns impacted by threat, mediated by cortisol	Methyl groups attach to promoter region or come off promoter regions of genes, leading to the transcription or lack of transcription of genes	Adult stress and reactivity behavior ^{231,232}
Immune function ⁸⁰	Alteration of immune system in response to constant threat	Inflammatory system up-regulated; humoral immunity diminished; cytokine-induced "sickness behavior" ⁸¹ (feeling sick)	Symptoms including the following: decreased appetite, fatigue, mood changes including depression and irritability, poor cognitive function

changes.^{12,14} The lifelong effects of toxic stress are statistically related to many adult illnesses, particularly those related to chronic inflammation, and causes for early mortality.²⁹ The robust literature on the physiologic effects of toxic stress is beyond the scope of this clinical report yet briefly summarized in Table 2.

Trauma is a broader term used to describe both a precipitant and a human response. The Substance Abuse and Mental Health Services Administration defines trauma as an event, series of events, or circumstances experienced by a person as physically or emotionally harmful that have long-lasting adverse effects on the person's functioning and well-being (emotional, physical, or spiritual).¹⁶ This definition accounts for the fact that people may respond differently to potentially traumatic events and informs TIC with appreciation that the traumas people experience can result in behavioral changes that may allow them to manage the trauma in the short-term but can have lasting negative effects on conduct. These difficulties should not be viewed as malicious actions or even intentional but as consequences of adversity.³⁰

Because these epidemiological and physiologic studies provide the background and impetus for TIC, understanding the terminology

derived from this literature is important in appreciating the scope, variety, and nuances of TIC and how to actualize them. These are summarized in Table 3.

High-risk Populations

It is important to be aware that the exposures of some child populations and their families put them at particular risk of experiencing trauma but also that the components of TIC can benefit these children and families.³¹⁻³⁴ More than 7.4 million children, or nearly 1 in 10 children, are reported as potential victims of child abuse and neglect annually.³⁵ In 2019, more than 670 000 children spent time in foster care.³⁶ Children who remain at home after child protective services investigation or are moved to kinship care resemble their peers in foster care in having an extremely high prevalence of significant childhood trauma.³⁷⁻³⁹ Immigrant and refugee children may have left poverty, war, and violence, may have encountered abuse or separation from family members, and can be at risk for deportation, detention, and separation and discrimination.^{6,40,41} Poverty, or near poverty, affects approximately 43% of US children, and both urban and rural poverty have been linked with multiple stressors and increased risk of trauma.⁴²⁻⁴⁴ Children of underrepresented racial, ethnic, and religious groups are

more likely to be exposed to discrimination.^{45,46} The psychological, interpersonal, and perhaps physiologic effects of trauma inflicted on a community (particularly because of race, identity, or ethnicity) may be passed to succeeding generations and is referred to as historical trauma.^{47,48} Community violence and bullying, along with cyberbullying, are experienced by many children and recognized as traumatic exposures included in expanded definitions of ACEs.⁴⁹⁻⁵¹ Lesbian, gay, bisexual, transgender, and queer children and adolescents, children of color, American Indian and Alaskan native children, immigrant children, neurodiverse children and adolescents, and children and adolescents with overweight and obesity are all more likely to experience discrimination, both overt and as a series of microaggressions (small slights, insults, or indignities either intentional or unintentional) that accumulate over time.⁵²⁻⁵⁴ Additionally, children of military families have a higher prevalence of trauma, abuse, grief, and loss.⁵⁵ Populations at higher risk for pediatric medical traumatic stress include preterm infants, children with complex and/or chronic medical conditions, and those suffering from serious injury or illness.⁵⁶ Up to 80% of children and family members experience trauma

TABLE 3 Definitions of Terminology in TIC

Terminology of Traumas	Definitions
Acute stress disorder and Post-traumatic stress disorder (PTSD)	Psychiatric diagnoses that include having experienced or witnessed a traumatic event and then having persistent symptoms that include the following: reexperiencing (intrusive thoughts, nightmares, or flashbacks); avoidance (feeling numb, refusing to talk about the event); hyperarousal (irritability, exaggerated startle response, always expecting danger); acute stress disorder: symptoms occur 3 d to 1 mo after traumatic exposure ⁸¹ ; PTSD: symptoms must occur ≥ 3 mo after the trauma ²³⁵
ACEs	Stressful or traumatic events, including child abuse and neglect, that occur within the primary caregiving relationship; often breach the parent-child relationship, which is fundamental to nurturing healthy development; linked in population studies to physiologic and behavioral changes impacting the health and well-being of patients over their life course with a wide array of health problems, including associations with substance misuse. ^{10,21,24,80} The original ACEs (from initial study published in 1998) are the following: physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, intimate partner violence, mother treated violently, substance misuse within household, household mental illness, parental separation or divorce, and incarcerated household member. Subsequent studies have expanded the original ACE panel to include other adversities, ^{9,234} including the following: experiencing racism, experiencing bullying, separation from caregiver (resulting from immigration, foster care, incarceration, death, or any other reason), witnessing violence, community violence, ⁴⁹ adverse neighborhood experience, ²³⁵ and financial insecurity ²³⁶
Complex childhood trauma (as defined by the National Child Traumatic Stress Network)	Encompasses both a child's exposure to multiple interpersonal traumatic events, including maltreatment and household dysfunction, and the broad, pervasive, and predictable impact this exposure has on the individual child ^{83,237} ; can disrupt a child's attachment with caregivers, development, and sense of self
Developmental trauma disorder (DTD)	A proposed diagnosis based on evidence that children exposed to complex trauma are at risk for severe pervasive disruptions in their development in the domains of emotional health, physical health, attention, cognition, learning, behavior, interpersonal relationships, and sense of self; sometimes used interchangeably with complex childhood trauma; describes problems in affect dysregulation, negative self-concept, and difficulty with relationships that occur as a result of trauma-related developmental impairments; symptoms overlap or co-occur with several PTSD symptoms, but DTD includes a fuller spectrum of dysregulation resulting from the insults to multiple pathways in the developing brain when nurturing and is seen as a result of complex childhood trauma; more accurately describes the outcomes of such trauma in children than does the diagnosis PTSD ^{158,238}
Pediatric medical traumatic stress (PMTS)	The distress that children and family members experience during hospitalization for a perceived life-threatening diagnosis or while living with or caring for someone with life-altering chronic conditions ²³⁹⁻²⁴¹ ; often related to the person's subjective experience of the medical event rather than its objective severity and is mitigated by SSNRs that promote resilience
Secondary traumatic stress (STS)	A response that may occur in parents, other family members, and health care workers such as physicians, nurses, other hospital staff (including nonclinical staff), first responders, and therapists who are exposed to the suffering of others, particularly children ²⁴² ; may have many of the same long-term effects on health that affect children exposed to trauma; individual trauma histories can contribute to the reaction
Social determinants of health (SDoHs)	Conditions of the greater ecology or environment, occurring where people live, learn, work and play, which affect the neuroendocrine stress response and affect a wide range of health risks and outcomes ^{8,22} ; can be mitigated by an SSNR and other protective factors and exacerbated by ACEs and intrafamilial and interpersonal traumas; examples include: poverty, food insecurity, homelessness, and lack of access to health care; examples that also overlap with the expanded ACEs include racism, discrimination, and community violence
Trauma	An event, series of events, or set of circumstances an individual experiences as physically or emotionally harmful that can have lasting adverse effects on the person's functioning and mental, physical, emotional, or spiritual well-being ¹⁴ ; can occur outside caregiving relationships (eg, dog bites, natural disasters), within the context of the caregiving relationship (eg, exposure to domestic violence, various forms of abuse or disordered caregiving because of parental mental illness or substance use disorder), or in the context of relationships outside the family (racism, bias, discrimination, bullying)

symptoms after a life-threatening illness, injury, or painful medical procedure.⁵⁷

READINESS

TIC transforms the fundamental questions in medical care from “What is wrong with you?” to “What happened to you?” and, finally, to “What’s strong with you?” A trauma-

informed approach acknowledges the biological effects of adversity without suggesting that childhood adversity is destiny. It requires a compassionate approach that does not suggest blame. It requires pediatric health care workers at every level to understand the context of a child’s relationships, especially within the family, and ask, “What are the caregiver’s strengths

and challenges?” “What are the child’s strengths and challenges?” and “Who supports you?” This changes the pediatric role from “I must fix you” to “I must understand you (and the relationships that created you and can help you heal).”^{25,58} Thus, readiness includes an understanding of what provides resilience and how to promote it.

Relational Health Care

TIC is fundamentally relational health care, the ability to form and maintain safe, stable, and nurturing relationships (SSNRs). Pediatricians are able to support the caregiver-child relationship, the context in which there can be recovery from trauma and the restoration of resilience. Fundamental to these concepts is an understanding of attachment.

Attachment

Attachment describes the emotionally attuned give-and-take between caregiver and child and the trust, safety, and security provided to the child⁵⁹ that promotes healthy brain growth, development of accurate mental maps of self and others, development of resilience, and protection from trauma.⁶⁰ Fundamentally, the predictable compassionate availability of the caregiver promotes the secure attachment of the child.^{61,62} Recent studies show attachment remains malleable beyond infancy, even into adolescence and adulthood, to some extent.^{63,64}

Effective Parenting

Effective parenting encompasses the skills that caregivers bring to the task of parenting and is the context in which secure attachment develops and is relied on during and after traumatic experiences. Although caregivers approach parenting with a range of skills, attitudes, and beliefs rooted in their cultural and family contexts, studies have shown that effective or positive parenting has some universal features.⁶⁵⁻⁶⁷

It is through secure attachment with a predictably empathic caregiver that children learn to regulate their emotions. Children start by turning to a caregiver when upset. The caregiver comforts the child by touch, words, and compassion, which shuts down the stress response and restores emotional

regulation. Secure attachment happens as a child predictably receives this sympathetic support from the caregiver when the child is distressed and the child comes to confidently anticipate that support. This relationship becomes a reliable source of safety, and the caregiver is a secure base from which the child can explore their environment.⁶² Multiple studies have shown that a secure attachment relationship is the best means for building or rebuilding resilience in children; it is also the context for promoting healthy brain growth and development.^{62,65,68,69} With these positive affiliative experiences, modulation of the stress response begins and includes the release of oxytocin, a potent hormone regulator of the sense of safety and well-being.^{68,70}

Thus, the first step of TIC is to assess this aspect of the relationship, observing the child-caregiver interaction, including the caregiver's attention to the child, the caregiver's ability to read and respond to the child in developmentally appropriate ways, and the child's ease, comfort, and response to the caregiver. Discussion can begin by focusing on the caregiver's and child's strengths and noting the constructive aspects of the relationship while providing the caregiver with empathy. When attachment is strained, caregivers have often lost empathy for the child. The positive regard and attuned attentive listening provided

before and while raising concerns supports the caregiver. The empathy provided to the caregiver thus allows the opportunity for them to reattune to the child.⁶²

Resilience

Resilience is defined as a dynamic process of positive adaptation to or despite significant adversities.⁷¹ This is not a static or innate quality but includes skills children can learn over time with reliable support from attachment figures. The development of resilience includes aptitudes that are attained through play, exploration, and exposure to a variety of normal activities and resources. Studies have shown that development can be robust, even in the face of severe adversity, if certain basic adaptational mechanisms of human development (resilience factors) are protected and in good working order. These mechanisms include attachment to a competent caregiver, cognitive development with opportunity for continued growth, mastery of age-salient developmental tasks, self-control or self-regulation, belief that life has meaning, hope for the future, a sense of self-efficacy, and a network of supportive relationships.⁷¹ On the other hand, if those basic adaptational mechanisms or protective factors are absent or impaired before, during, or after the adversity, then the outcomes for children tend to be poorer⁷¹ (see Table 4).

TABLE 4 Adaptational Mechanisms of Resilience

T	Thinking and learning brain, with opportunity for continued growth; cognitive development
H	Hope, optimism, faith, belief in a future for oneself
R	Regulation (self-regulation, self-control of emotions, behaviors, attention, and impulses)
E	Efficacy (self-efficacy) or sense that one can impact their environment or outcomes
A	Attachment, secure attachment relationship with safe, stable, and nurturing caregiver or competent caregiver
D	Development, mastery of age-salient developmental tasks
S	Social context, or the larger network of healthy relationships in which one lives and learns

Adapted from Masten AS. Ordinary magic. Resilience processes in development. *Am Psychol*. 2001;56(3):227-238; Forkey H, Griffin J, Szilagyi M. *Childhood Trauma and Resilience: A Practical Guide*. Itasca, IL: American Academy of Pediatrics; 2021.

Robust implementation of TIC is strength-based, building on family protective factors rather than emphasizing deficits. At almost every encounter, from early childhood through adolescence, pediatric care can include resilience promotion, building on identified strengths. Because resilience is a dynamic process of positive adaptation, routine anticipatory guidance about development or safety can be used to promote relational health and positive childhood experiences, including achievements at home, at school, and in neighborhoods, which enhance resilience.⁷² When addressing adversities or concerns about development, surmounting the challenges can be framed with resilience and positive experiences as the goal.⁷³ For example, when speaking with a caregiver about a child learning to fall asleep on their own, sleep skills can be framed as building resilience by supporting self-regulation and self-efficacy. Alternatively, when a caregiver expresses concern about a child or teenager who had been sleeping until experiencing a traumatic event, the discussion can be framed around what resilience factors are being challenged (developmental skill mastery, self-efficacy, self-regulation) and which ones can be used to support the child's recovery (attachment and thinking).

DETECTION AND ASSESSMENT

Detection involves both surveillance and formal screening to identify children and families with the history of exposure to potentially traumatic experiences as well as those who exhibit signs and symptoms of trauma. Although TIC is common in social services and other mental health settings, in a health care environment, TIC can be conceptualized by using a medical model. Similar to other medical conditions, TIC includes purposeful

triage, engagement, history-taking, surveillance and screening, examination, differential diagnosis, sharing of the diagnosis, and management, which may include office-based anticipatory guidance, referral, psychopharmacology, and/or follow-up or recommendations.

Surveillance for maladaptation after experiencing trauma includes consideration of all those who may be affected by exposure to the direct suffering of the child. Health care workers, such as first responders, nurses, social workers, trainees, physicians, and nonclinical hospital or clinic employees, may be deeply affected by witnessing or hearing about the traumatic experiences of children. Parents (biological, foster, kinship, or adoptive) are particularly at risk for prolonged trauma reactions that may impair their ability to care for and comfort their children. Siblings may also be affected, particularly when there is complex trauma or exposure to suffering, such as having a sibling with cancer or another life-altering disease that involves chronic pain.

Peri-trauma

Peri-trauma refers to situations in which medical providers are caring for children as the traumatic events are unfolding. One example is pediatric medical traumatic stress. Pediatric medical traumatic stress is a situation in which children experience medical procedures or other aspects of medical care as traumatic events. The effects of such trauma can be mitigated by attending to the child's and family's experience of medical care and reducing (as much as possible) frightening or painful aspects of necessary care and procedures. This mitigation can include asking children (and caregivers) about their fears and worries, optimizing pain management and comfort measures, and working with

caregivers to increase their ability to provide effective support for their child. The Healthcare Toolbox includes a number of specific suggestions, including assessing distress (D), providing emotional support (E), and addressing the family needs (F)—a D, E, F protocol to follow the A, B, Cs of resuscitation.⁷⁴

Another comprehensive strategy used by schools and community agencies when a mass trauma or disaster occurs is Psychological First Aid (PFA).⁷⁵ Developed by the National Child Traumatic Stress Network, PFA is an evidence-informed program that is designed to help children, families, adults, and other witnesses in the immediate aftermath of a disaster or terror event. Core skills for implementation of PFA are identical to TIC: establish an emotionally safe environment, connect with primary support persons (relational health), link to community resources, and provide psychoeducational materials to help understand the potential responses of children to the exposure.

Triage

The first step in medical care is to identify an emergency versus nonemergency situation. When dealing with trauma, its causes, or its consequences, consideration of whether a child may be emergently at risk requires assessment and response as a top priority. In practicing TIC, protocols and practices to identify and address child or family safety issues, both physical and psychological, are integral to care.

Trauma may result from children being in unsafe settings because of abuse, neglect, or impaired caregiving. When the practitioner suspects maltreatment or failure of the caregiver to protect a child at any point in a health encounter, referral to child protective services

is necessary and mandated. These issues need to be considered even before screening and addressed with standard protocols to respond to identified risks.⁷⁶⁻⁷⁸

Other immediate safety issues may arise when a consequence of trauma is self-harm or intent to injure others. Screening for suicidality, self-injury, or intent to harm others is included in TIC along with clear protocols for how to address positive endorsement of these issues.

Engagement

TIC creates a respectful and emotionally safe space in which to engage children, adolescents, and families around the discussion and management of these issues and to prevent retraumatization. Discussion of trauma may raise stress levels, and appropriate engagement reassures the child and family that the setting is safe. Culture can also affect how trauma is experienced and understood by families, and cultural awareness can ease the conversation. Engaging children and families begins with greeting the patient and family and being fully present in the moment while maintaining a balance between professionalism and friendliness. It involves initially asking open-ended questions, followed by more specific and probing questions as needed and that are elicited by caregiver and child or adolescent responses. It involves listening in an active, nonjudgmental, attuned way, reflecting back to the family what is heard for clarification and confirmation, seeking clarification when necessary, paraphrasing, attending to and reflecting on the emotions that accompany the information, and summarizing what is discussed. Implicit bias can affect the provider's ability to be nonjudgmental in these conversations.^{46,79} Acceptance,

curiosity, and empathy are conveyed to the patient or caregiver in the process of attentive listening.⁶¹ Engagement also involves mutual regard between the provider and family. Adolescents and capable children bring their own perspective. Each brings expertise to the TIC of the child or adolescent. The provider has expertise in medicine, whereas the patient and family have expertise about the child, what happened, and their situation, beliefs, strengths, and culture.

When working with families and patients who have experienced trauma, the provider's body language, affect, and tone of voice can promote or inhibit care. Affect describes the facial and body expressions that reflect our emotional state. Individuals who have experienced trauma are more sensitive to body language, facial expressions, and tone of voice.⁷⁰ Approaching children slowly and calmly or letting them sit with a caregiver and using higher pitched, more musical speech may ease a child's tension because these sounds are associated with the release of oxytocin in the amygdala, resulting in calming of this threat-sensitive brain area. A shift to low tones during a discussion may alert a child or caregiver to potential danger and stimulate defensive responses.⁶¹

History

Much of the information needed to integrate TIC into practice may be obtained as part of the routine health evaluation. Social, developmental, and medical history are all opportunities to identify risks, stressors, and strengths. The health history provides an opportunity to assess child and family resilience factors, social connectedness, parenting attitudes, and skills. The review of systems allows the medical provider to

collect symptoms of trauma that may not have been identified in the chief complaint but that can offer valuable insight into the current impact of trauma on the patient.^{80,81} Symptoms may be functional, neurodevelopmental, or related to immune function.

1. Functional symptoms: Manifestation of the symptoms of trauma may evolve over time. Functional complaints can result after single-incident traumas (eg, automobile crash, hurricane) or may be early manifestations of complex trauma.⁸²⁻⁸⁴ Sleep difficulty, changes in appetite, toileting concerns (eg, constipation, abdominal pain or enuresis), and challenges with school functioning (eg, poor attention or attendance) may be the early presentation of ongoing trauma.^{84,85} Diagnostic criteria for attention-deficit/hyperactivity disorder and adjustment disorder overlap with some of these functional symptoms. When these signs and symptoms are noted, it can be useful to include trauma in the differential diagnosis.^{17,86,87}
2. Neurodevelopmental symptoms: Some of the most recognizable manifestations of early trauma result from the effect on areas of the rapidly developing brain of young children. Developmental skill acquisition (higher brain) can be hindered as recognition of and response to threat is prioritized (lower brain).^{88,89} Specific areas of the brain affected are the limbic system, hippocampus, and prefrontal cortex.^{12,13,90-92} The prefrontal cortex is involved in cognition, emotional regulation, attention, impulse control, and executive function. Consequently, children may have developmental delay and behave as if they are younger than their actual age^{89,93} (see Table 5 for an easy way to remember these effects). Other

TABLE 5 Most Common Symptoms of Trauma Exposure

F	Frets (anxiety and worry) and fears
R	Regulation difficulties (disorders of behaviors or emotions; hyperactive, impulsive, easily becomes aggressive or emotional; inattentive)
A	Attachment challenges (insecure attachment relationships with caregivers); poor peer relationships
Y	Yawning (sleep problems) and yelling (aggression, impulsivity)
E	Educational and developmental delays (especially cognitive, social-emotional, and communication)
D	Defeated (hopeless), depressed, or dissociated (separated from reality of moment, lives in own head)

Adapted from Forkey H, Griffin J, Szilágyi M. *Childhood Trauma and Resilience: A Practical Guide*. Itasca, IL: American Academy of Pediatrics; 2021.

observed symptoms may include the following:

- rapid, reflexive response to stimuli, reminders, or triggers^{93,94};
 - inattention, poor focus, hyperactivity, and difficulty completing tasks^{86,95};
 - difficulty tolerating negative mood so the child seeks ways to defuse the tension through hyperactivity, impulsive behaviors, aggression, self-harm, such as cutting and suicidality, or engagement in health risk behaviors (substance use, sexual activity)^{89,95,96};
 - reactions to stimuli, triggers, or reminders can be transient and flip suddenly back to “normal”; this appears to the observer as emotional lability^{88,92}; and
 - negative world view and self-narrative; flat affect; difficulty engaging socially or viewing themselves as worthless.^{88,92,97}
3. Immune function symptoms: When a child is exposed to early, severe, or prolonged trauma, the immune system is chronically pressed into action, and, over time, changes can occur in the inflammatory system and humoral immunity.^{80,89} A persistent inflammatory response can leave children vulnerable to diseases, such as asthma and metabolic syndrome.^{80,98,99} Humoral immunity may be impaired so that children are more susceptible to infection. Additionally, immune system stimulation may result in the “sick syndrome,” which is a

perception of feeling unwell that can include headaches, stomachaches, and lethargy.^{80,81}

Surveillance

Surveillance or monitoring is the process of recognizing children who might be at risk for being affected by trauma and is modeled after developmental surveillance. Surveillance is less formal than screening and can be conducted at every visit. Asking about caregivers’ concerns, obtaining a trauma history, observing the child, and identifying risk and protective factors provides information about resilience supports and trauma exposure.¹⁰⁰ Surveillance requires attention to relationships and engagement. Questions such as “Has anything scary or concerning happened to you or your child since the last visit?” are a way to more specifically explore the possibility of adverse experiences.⁸⁵ Recognizing that certain symptoms may indicate exposure to childhood adversities, we can ask, “What has happened to you (or your family)?” For adolescents, these questions can be asked as part of the HEADSSS (questions about Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/depression, and Safety) psychosocial interview.^{101,102} Questions that are considered less threatening are asked first and followed with questions that may be perceived as more intrusive.¹⁰¹ Providers may be

concerned that asking questions about a family’s needs, a child’s trauma history, or a child’s symptoms may distress the child or caregiver, but studies in which this topic has been explored indicate that, when the topic is raised, families respond well to having the issues acknowledged and addressed in a supportive setting.^{85,103,104}

Children only heal from trauma in the context of SSNRs, so it is also necessary to ask about the strengths that are already present in the family. Starting these conversations with questions about child, adolescent, or family strengths frames the conversation in a positive and resilience-focused way.^{105,106} For instance, a clinician may ask how the child, adolescent, or family copes with stress, what a teenager does well, whether they have frequent family meetings to talk about solving problems, and whether each member of the family has someone to turn to for safety and comfort when they are upset. Trauma that occurs because of problems in the primary attachment relationship represents the greatest threat to the child or adolescent and may be the most challenging for providers to explore. Caregivers may have their own trauma histories or mental health struggles, substance use issues, and/or multiple stressors related to social determinants of health (SDoHs), including poverty, housing instability, and violence exposure that affect their parenting. Exploring parenting stressors, strengths, and attitudes in conversation can help the provider to pinpoint specific leverage points to help children but may also create an opportunity for the caregiver to reflect about the effects of their parenting or stressors on the child. TIC is compassionate and assumes that all caregivers love their children and are doing the best they can. It also assumes that children

are doing the best they can.^{107,108} Adolescents should be included in these conversations and have a role in identifying strengths and challenges. Pediatricians who have cared for a family over time may already have considerable insight into the family's dynamics and be able to engage the caregivers in an empathic yet open conversation. Furthermore, compassionate surveillance can be combined with use of screeners or questionnaires to elicit more information.

Screening

Validated screeners used at preventive health care visits can provide valuable information about child development, mental health, and behavior.¹⁰⁹ They can be reassuring when normal or alert the pediatric provider to symptoms or risks when borderline or abnormal. Commonly used tools, such as the Ages and Stages Questionnaire,¹¹⁰ the Pediatric Symptom Checklist,¹¹¹ the Strengths and Difficulties Questionnaire,¹¹² and the Patient Health Questionnaire-9¹¹³ may elicit symptoms that are the possible result of trauma (developmental delays, social-emotional problems, anxiety, etc). Perinatal depression screening may not only identify symptoms of this illness but provide opportunities to explore maternal stressors and strengths.¹¹⁴ Those exposed to known traumas can be evaluated by using standardized posttraumatic stress disorder (PTSD) screening tools such as the PTSD Reaction Index Brief Form,¹¹⁵ and those exposed to medical traumas can be evaluated by using a tool such as the Psychosocial Assessment Tool.^{116,117} The Pediatric Traumatic Stress Screening Tool in the Intermountain Care Process Model has been recently developed to screen for pediatric traumatic stress in the primary care setting, either as a universal screen or with targeted screening when

traumas are known.¹¹⁸ These tools effectively help identify the diagnostic criteria for PTSD, although they are not designed to identify the full spectrum of symptoms of complex trauma (developmental trauma disorder [DTD]).

Screening, per American Academy of Pediatrics (AAP) guidelines, suggests using instruments that are standardized and validated and have defined psychometric properties (sensitivity, specificity, positive predictive value). By that definition, there are currently no screening tools for ACEs and only a few validated screening tools for SDOHs. However, standardized (but not validated) tools are being used in some pediatric settings to assess ACEs and SDOHs and are using aggregate risk scoring to target providing increased support.^{119–121} Many of the available screening tools expanded on the domains included in the original Centers for Disease Control and Prevention/Kaiser ACE study to include additional items applicable to urban and minority populations, including witnessing neighborhood violence and experiencing bullying or discrimination.⁹ Parental ACE screening may offer the opportunity to align with caregivers and build a partnership to explore issues that may be affecting their parenting. Indeed, several recent studies suggest that parental ACEs can be linked with concerning outcomes for children.^{122–125} Concurrent resilience screening offers the opportunity to identify protective factors that can buffer identified stressors, thus providing more nuanced understanding of a child's risk. Screening also offers the opportunity to then frame the discussion around promoting strengths in the caregiver-child relationship to protect a child from toxic stress and build adaptive

skills.¹⁰⁷ Similar to ACE screening, there are few available standardized validated resilience screening tools, although the Connor-Davidson Resilience Scale¹²⁶ and Brief Resilience Scale¹²⁷ assess caregiver resilience.¹²⁸ (Readers are referred to the AAP Screening Technical Assistance Web site at <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/About-Us.aspx> for developmental and SDOH screening tools.)

A limitation of ACE and SDOH screening tools is their lack of nuance: they identify risk factors that have been derived from epidemiological studies, not outcomes at the individual level.^{129,130} Those outcomes are the result of the physiologic response to adversities. Although currently only available in the research setting, biomarkers of this physiologic response have the potential to be more accurate measures of the effects of adversity at the individual level.^{131–133} Eventually, clinic-friendly, noninvasive biomarkers could also be used to identify patient-specific response to both stressors and therapeutic interventions.^{134,135}

Screening health care workers for the effects of hearing about and addressing the trauma experiences of others is most commonly achieved with informal self-assessment strategies to identify symptoms or experiences that may be associated with burnout or STS.¹³⁶ Substance use disorder, depression, and suicidality may be associated with exposure to secondary trauma, and there appears to be overlap between burnout and STS.^{137–144} An example of a screening tool for health care workers is the Professional Quality of Life Scale,¹⁴⁵ which includes subscales for compassion satisfaction, burnout, and STS.

Cultural considerations affect all aspects of TIC, including screening. Instruments that are not normed for the population or translated and validated in the language of the patient and family can result in misleading results. Thus, it is important to consider screening results cautiously with consideration of the family's culture and ethnicity in relation to the screening tool being used.¹⁴⁶

Examination

Blood pressure measurement at preventive health visits or when stress is a potential etiologic factor for concerns is indicated.¹⁴⁷ Elevated blood pressure may be the first symptom of childhood traumatic stress, especially as youth age.^{148,149} Abnormalities in hearing, vision, and growth parameters can be clues to adversities.^{150,151} Overweight and obesity have been associated with ACEs.¹⁵²⁻¹⁵⁴ Physical examination may reveal signs of neglect or abuse. The immunologic effect of trauma may result in inflammatory or infectious consequences identifiable on examination.^{1,80,99,155,156} Children who have sustained cumulative ACEs and traumas may exhibit certain common behaviors the provider may witness during physical and mental health evaluation (refer to history and symptoms described earlier).

Differential Diagnosis Considerations and Comorbidities

The provider is encouraged to consider trauma as a possible etiology in the assessment of developmental, mental health, behavioral, and physical symptoms in all pediatric encounters because of the following: (1) the experience of adversity is so common; (2) the symptoms of trauma overlap with the symptoms of other common pediatric conditions^{87,95}; and (3) failure to do so might lead to an

incorrect or incomplete diagnosis and treatment, enabling the effects of trauma to further embed.^{17,157,158} Trauma may be mistaken for other conditions, such as attention-deficit/hyperactivity disorder, and includes symptoms that overlap with other diagnostic categories, such as anxiety and depression.^{86,87,159} It has been proposed that trauma may result in a different "ecophenotype" of common conditions that have a different trajectory and different response to common treatments.⁹³ Children may also have comorbid conditions, such as ADHD, anxiety, depression, or developmental and learning issues, because they frequently accompany childhood trauma. A more detailed description of diagnoses that are commonly confused with trauma or comorbid with it are covered in the AAP clinical report "Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication."⁸⁷

Diagnostic Continuum

Pediatric providers may encounter children with a wide range of symptoms resulting from trauma. As noted, trauma can result in short-term changes in behavior or have a more lasting impact depending on the child, the trauma itself, and the supports or emotional buffers in a child's life. When traumatic events are more severe, prolonged, or less buffered by a caregiver, effects on various aspects of functioning can be more severe.^{1,160-163} Children exposed to chaotic households, abuse, or neglect, especially in the early years of life, may have more severe symptoms and symptoms that evolve over time.^{94,159,164,165} Diagnostically, this may result in children who have functional symptoms (short-term problems with sleeping, eating, toileting), adjustment disorder, PTSD, or complex trauma symptoms.^{163,166,167}

MANAGEMENT

Sharing the Diagnosis With Children and Caregivers

Some parents and caregivers may come to understand the role of adversities in their child's symptoms through discussion of the trauma history and symptoms, and others will require the provider to explain this connection before they can appreciate the provider's advice and recommendations. Psychoeducation is the first step in management of childhood trauma and includes empathic, nonjudgmental sharing of diagnostic information and provider concerns about the etiology of a child's symptoms. The provider's role is to integrate the child or adolescent and caregiver's concerns, the child or adolescent's symptoms, and elements of a thorough history and examination into an explanation of why this raises a concern about trauma exposure or why trauma may be the underlying cause or one of the causes of a child's symptoms, much as is done for any diagnosis. A simple explanation of the pathophysiology of trauma may help the caregiver to move from frustration with the child or adolescent's behaviors or symptoms to empathy. In some situations, the explanation may also provide the caregiver with insight into their own history of trauma and its impact on their parenting behaviors or responses to their child's behaviors, or how an event that affected their child may have traumatized the caregiver as well.

Psychoeducation includes acknowledging that a trauma history can affect behavior and thoughts, with some discussion of how that happens. Table 6 has information on specific psychoeducation. The variable responses of children to trauma can be frustrating or confusing. Discussion of the emerging data on the biological sensitivity to context may be useful

TABLE 6 Responses to Trauma to Explain to Caregivers: Psychoeducation

Impacts of Trauma on Function and Behavior	Clinical Presentation
Changes in auditory processing	Children may lose the ability to hear sounds of safety (musical high-pitched voice) and be preferentially attuned to low-pitched sounds that warn of caregiver depression and anger. ²⁴⁷
Changes in how children interpret facial expressions	Children may misinterpret the affects and emotions of others, particularly confusing anger and fear. ⁹³
Limited vocabulary for emotions	Children may also not accurately recognize or express their own emotions, leading them to act out or respond in ways that seem “off.” What a child (or caregiver) identifies as “anger” may be disappointment, frustration, fear, grief, or anxiety. ⁸⁸
Negativity	Trauma results in children having overactive limbic systems with a focus on safety and a presumption of danger. This can result in strong negative reactions as the first response to a stimulus that might be benign or ambiguous. ⁶¹
Triggers	Triggers can be physical (smells or sounds that recall details of the trauma) or emotional (feeling embarrassed or shamed, recalling how child felt during abuse). Prevention of exposures to reminders or triggers is the best approach. Triggers may be subtle, so educating and assisting caregivers with their identification is key. This helps caregivers understand a child’s response. ¹⁶⁷
Learned Behavior	Behaviors that were adaptive for a child in a previous environment may be maladaptive in their current environment. These behaviors can evoke some of the same reactions from caregivers that the child experienced with other adults, reinforcing a familiar pattern of interactions that may not be productive in the new setting. ⁶¹

Adapted from the National Child Traumatic Stress Network. Families and caregivers. Available at: <https://www.nctsn.org/audiences/families-and-caregivers>. Accessed January 11, 2021;²⁴⁵ US Department of Health and Human Services, Administration for Children and Families. Resources on trauma for caregivers and families. Available at: <https://www.childwelfare.gov/topics/responding/trauma/caregivers/>. Accessed January 11, 2021²⁴⁴; and American Academy of Pediatrics. Parenting After Trauma: Understanding Your Child’s Needs. Available at: <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FamilyHandout.pdf>. Accessed June 24, 2021²⁴⁵.

to caregivers.^{168,169} Genetic variations in how a person responds to stress may contribute to a child’s sensitivity to adversity.¹⁷⁰ Yet, those with high reactivity who are supported and learn to channel that reactivity to positive activities and passions may have the greatest potential.¹⁶⁸ This information, along with specific suggestions about how to support children, can address some of the consternation of caregivers regarding children’s heterogeneous responses to both adversity and interventions.

Office-Based Anticipatory Guidance and Management

Trauma-informed anticipatory guidance provided by pediatricians can help families promote resilience and begin to address the effects of trauma. If screening for SDOHs is being conducted and/or social needs are identified, referral to applicable community-based services is indicated (eg, food bank, pro bono legal aid, etc). Having a list of community providers, such as Early Head Start, Head Start, evidence-based maternal, infant, and early childhood home visiting programs,

state Maternal Child Health Title V programs, and Family to Family Health Information Centers ready for distribution, directly contacting the referral provider with the patient present, or providing formal care coordination all facilitate family engagement and help families connect to needed community resources. For older children and adolescents, trauma-informed schools and teenager crisis centers may be available in the community. In trauma-informed schools, personnel at all levels have a basic realization about trauma and an understanding of how trauma affects student learning and behavior in the school environment.^{171,172}

Every encounter in an office setting, from those with young children to those with adolescents, is an opportunity to strengthen the attachment between a child and caregiver.¹⁷³ Through techniques such as reinforcing positive back-and-forth interactions between a parent and a child (serve and return), helping the caregiver to understand the child’s experience (keeping the child’s mind in mind),

helping the children to learn words to describe a variety of emotions, and promoting self-reflection concerning the caregiver’s own trauma history, the pediatric clinician can render primary prevention against the development of anxious and maladaptive attachment patterns and promote regulation.^{82,174} Examples of relevant anticipatory guidance include advice, resources, or referrals to community programs, including Reach Out and Read^{175–177}; developmentally appropriate play with others^{178–180}; promoting positive, authoritative (in contrast to punitive or authoritarian) parenting styles^{181–183}; and mindfulness.^{184–186} Table 7 includes specific advice to promote regulation after trauma.

Referral for Treatment

The presence of complex symptoms, mental health diagnoses, substance abuse, and/or a significant trauma history are indications for referral to evidence-based trauma-informed mental health services.

TABLE 7 Anticipatory Guidance

Office-Based Guidance to Promote Regulation After Trauma	
Restoring safety	To reduce the stress response after trauma, caregivers can: repeatedly assure a child or teenager that they are safe now; allow the youth to express how they feel and listen attentively; provide extra physical contact (if appropriate) with hugs, touch, and rocking for younger children.
Routines	Routines or rituals also help reduce the stress response after the unpredictability and chaos of trauma by restoring a sense of order. Caregivers can use visual (pictorial schedule or charts) and verbal cues for well-defined mealtimes, sleep times, and rituals (“Before bed, we are going to brush teeth, read a story, sing a song, and then turn lights out”). Preparing children for changes in routines, or, for the child in foster care or the child of separated or divorced parents, for visitation, can reduce stress responses.
Relaxation techniques	Provide information verbally, with printed instructions or on phone apps that guide relaxation, meditation, and mindfulness. Refer to community programs that provide training in belly breathing, guided imagery, meditation, mindfulness, yoga, stretching, and massage, which can help to reduce the fight-or-flight responses and symptoms. ²⁴⁷
Time-in or special time	Dedicated, child-chosen or child-directed play with a caregiver. Caregiver chooses a time that works for them and plans to spend 10 to 30 min with the child in fun activity of child’s choosing. For infant or toddler, reading time is a good example of “time-in.” Recommended for children from early childhood through adolescence.
Small successes	Children who experience trauma may have delays in skill development. Expectations may need to be tailored to the child’s developmental level rather than actual age. It may take lots of repetition and practice before a skill or behavior is learned, so it is useful to celebrate and reward small steps toward desired behaviors.
Emotional container	Child may have strong emotions if reminded of trauma, and the emotions may be directed at the caregiver, although they are usually not about the caregiver. Caregiver needs to remain calm to model self-regulation and avoid retraumatizing the child.
Cognitive triangle	Thoughts impact feelings, which then impact behavior, which then reimpacts thoughts. For example, if children worry they cannot fall asleep, they will then feel nervous and stressed, and then not be able to fall asleep, reinforcing their cognitive belief that they cannot fall asleep. Similarly, if children think no one likes them, they will feel rejected and may lash out at another child, leading to rejection by that child and reinforcing their belief that they are not liked. It can help to identify this triangle and break the link between thoughts and emotions (through new experiences that link thought with different emotions) and/or the link between the emotions and the behavior (“It is ok to feel ____, but it is better to do ____ than to do ____.” This technique involves labeling the emotions and teaching an alternative behavior.)
Distraction	Children who are dysregulating may benefit from distraction from the traumatic thoughts by suggesting a game, music, calling a friend, or deep breathing in a calm environment.
Positive parenting techniques	Positive parenting techniques have to be adapted to the age and developmental stage of the child, but they are principles that are known to work: (1) helping children identify and name their emotions; the next step for the child is to understand the emotion and then to learn healthy ways to express the emotion and build regulation skills; (2) reassuring safety and keeping the child safe both emotionally and physically; (3) attuned, attentive listening, which starts in infancy with “serve and return” but evolves into conversational exchanges over time; (4) setting appropriate boundaries and providing guidance through connecting and listening with children; it is best to teach rather than tell or command; for example, “We draw on paper, not on walls, because it is hard to wash markers off the walls”; (5) catching the child being good and offering the child positive, specific praise for good behaviors; (6) implementing rewards and privileges to create opportunities to develop skills; start small so the child can earn a reward quickly and then build up; (7) using positive language instead of “no” commands: for example, “We color on paper, not on the table,” is a better way to approach a child who is drawing on the table than, “Stop that,” Or, “we use gentle hands—we don’t hit others”; (8) being a good role model as child mimics what they see rather than what they are told; (9) having some fun together as a family (time-in): read, talk, sing, play; (10) reinforcing positive skills as they develop: cooperation, politeness, appropriate assertiveness, kindness, etc; and (11) the law of natural consequences: sometimes the best lesson is letting the consequences play out (not cleaning your room means it will be a mess when your friends come over).

Adapted from Camoirano A. Mentalizing makes parenting work: a review about parental reflective functioning and clinical interventions to improve it. *Front Psychol*. 2017;8:14; Zuckerman B, Augustyn M. Books and reading: evidence-based standard of care whose time has come. *Acad Pediatr*. 2011;11(11):11–17; Zuckerman B, Khandekar, A. Reach Out and Read: evidence based approach to promoting early child development. *Curr Opin Pediatr*. 2010;22(4):539–544; Needlman R, Tokar KH, Dreyer BP, Klass P, Medelsohn AL. Effectiveness of a primary care intervention to support reading aloud: a multicenter evaluation. *Ambul Pediatr*. 2005;5(4):209–215; Mendelsohn AL, Cates CB, Weisleder A, et al. Reading aloud, play, and social-emotional development. *Pediatrics*. 2018;141(5):e20173393; Shah R, DeFrino D, Kim Y, Atkins M. Sit Down and Play: a preventive primary care-based program to enhance parenting practices. *J Child Fam Stud*. 2017;26(2):540–547; Chang SM, Grantham-McGregor SM, Powell CA, et al. Integrating a parenting intervention with routine primary health care: a cluster randomized trial. *Pediatrics*. 2015;136(2):272–280; Girard LC, Doyle O, Tremblay RE. Maternal warmth and toddler development support for transactional models in disadvantaged families. *Eur Child Adolesc Psychiatry*. 2017;26(4):497–507; Weisleder A, Cates CB, Dreyer BP, et al. Promotion of positive parenting and prevention of socioemotional disparities. *Pediatrics*. 2016;137(2):e20153239; Shah R, Kennedy S, Clark MD, Bauer SC, Schwartz A. Primary care-based interventions to promote positive parenting behaviors: a meta-analysis. *Pediatrics*. 2016;137(5):e20153393; Perry-Parrish C, Copeland-Linder N, Webb L, Sibinga EMS. Mindfulness-based approaches for children and youth. *Curr Probl Pediatr Adolesc Health Care*. 2016;46(6):172–178; Bauer CCC, Caballero C, Scherer E, et al. Mindfulness training reduces stress and amygdala reactivity to fearful faces in middle-school children. *Behav Neurosci*. 2019;133(6):569–585; Ortiz R, Sibinga EM. The role of mindfulness in reducing the adverse effects of childhood stress and trauma. *Children (Basel)*. 2017;4(3):16; Forkey H, Griffin J, Szilagyi M. *Childhood Trauma and Resilience: A Practical Guide*. Itasca, IL: American Academy of Pediatrics; 2021.

The most effective therapies are evidence-based treatments (EBTs) with demonstrated efficacy for children who have experienced trauma.^{85,187,188} Treatments that are designated as evidence based have had the most rigorous evaluation, whereas evidence-informed treatments range from newly emerging practices that are building evidence support to less rigorously studied tools. Sege et al¹⁸⁹ published an overview of evidence-based individual and family-based psychotherapeutic interventions. Gleason et al¹⁹⁰ specifically outlined services for the treatment of young children. Having these services available on-site or through direct communication with colleagues in mental health (a “warm handoff”) has been revealed to be the most effective approach.¹⁹¹ It is important for caregivers who have their own history of trauma to seek individual therapy, and the pediatric provider may find it useful to have a list of adult mental health providers who address trauma. As research continues to elucidate the neurocognitive basis of trauma symptoms and methods to address those effects, new treatment modalities are being developed and may offer increased therapeutic resources for both adults and children.^{192–194}

Even if therapies are not available on-site, it is useful to familiarize self and staff with evidence-based trauma therapies, how they work, how to refer locally and how to incorporate principals of treatment into pediatric anticipatory guidance. A quick reference for EBTs that includes a brief description of each and the level of evidence can be found on the California Evidence-Based Clearinghouse for Child Welfare (<http://www.cebc4cw.org/>). Some EBTs have been successfully adapted for telehealth,^{195,196} and, in the wake of the coronavirus disease

2019 pandemic, opportunities for EBT via telehealth have expanded.¹⁹⁷ Telehealth is a mechanism to provide EBT in rural and other underresourced communities.¹⁹⁶

Psychopharmacology

No medication, to date, is approved by the US Food and Drug Administration for trauma-specific symptoms or PTSD in children and adolescents. Medications may be judiciously considered for specific symptoms that are interfering with a child’s ability to function normatively in specific ways.⁷² Readers are referred to the AAP clinical report “Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication” for discussion of medication use in identified comorbid mental health conditions.⁸⁷

Role of Close Follow-up and Support

A commitment to working with the family over time may prevent or reduce feelings of abandonment or rejection, especially when community and mental health resources are in short supply. The pediatric provider who is continuous over time can continue to listen attentively and offer practical trauma-informed advice that reinforces resilience building and healing. Obtaining consent to share information with a mental health provider may also be reassuring to the caregiver or patient even after a referral and linkage to mental health care is established.

Integration

Once these aspects of care are part of a provider’s repertoire of care, integrating knowledge about trauma into policies and procedures and daily practice are the next steps in creating a trauma-informed medical setting.^{198,199}

Train All Staff in TIC

All staff, from schedulers to billers to nurses and care coordinators, can benefit from training in TIC that is thorough and discipline specific and includes information about physiology, presentation, recognition, and response.^{15,200,201} This training would ideally promote patient empowerment and include caregiver and patient perspectives.

Implementing TIC in any setting is effective when there is consideration of clinic workflow to maintain efficiency. Specific strategies can include a warm and welcoming waiting room, clear communication of expectations and procedures, and providing choices when possible (eg, do you want blood pressure taken on right arm or left?).²⁰¹ As noted earlier, the care of a child who has experienced trauma requires an approach that is similar to addressing other health concerns. TIC can include members of the staff, all aware of and empowered to emphasize safety, patient self-efficacy, and a trauma-informed approach.^{15,201} Use of formalized training in TIC for all staff has been found to be effective in changing staff-reported beliefs and behaviors for caregivers of children in residential care^{202,203,204} and in improving child functioning and behavioral regulation.²⁰⁴ In pediatrics, training of pediatrics residents caring for substance-exposed infants in TIC was effective at changing attitudes and improving therapeutic relationships.²⁰⁵

Office personnel may engage with caregivers and patients in ways that trigger strong emotions, especially if they themselves have experienced adversity or trauma. Financial considerations, scheduling, and conflict in the small spaces of an office can also be explored from a TIC perspective. Personnel would ideally engage in some planning

about how to handle a crisis or difficult situations that occasionally arise, such as the following: patients or caregivers who are indifferent or shut down, demanding, provocative, rejecting or hostile, or inattentive and distracted; or a child who is out of control and threatening to elope from the office. It is helpful to monitor one's own response when difficult situations arise and resist the urge to be angry or retaliate. It is less provocative to focus or comment on the emotion than the behavior: "I can see that you are angry, worried, sad, upset, etc," or "You probably don't want to be here right now." These responses are more affiliative and can help to shut down the stress response of the patient or caregiver whose fight-or-flight response may have been triggered by the health care setting, the interaction, or the medical stressor.

Integrated Health Care

Many providers find that the most efficient TIC can be provided by integrating physical and mental health services and social supports. Integrated care has been found to increase social-emotional screening rates²⁰⁶ through colocation of services with clear strategies for medical provider introduction of the patient to the behavioral health consultant in real-time (warm handoff), by reducing the stigma of a mental health referral, or through facilitated or prearranged referral protocols.^{191,207} Financial and staffing resource issues vary significantly by region, but investigating opportunities for primary care and mental health integration, social work, and/or formal engagement of referral sources and partnering organizations may increase the efficiencies of TIC. Providing case management to address the social modifiers of health (eg, referral to food bank, legal aid) can help to increase family resilience and

prevent the consequences of trauma. Referring to resources has been revealed to be associated with increased employment, use of child care, and a decrease in the use of homeless shelters.²⁰⁸

Two-Generation Approach

Growing evidence has linked increasing parental ACE scores and negative effects on child health and development,^{122,123,125,209} providing compelling evidence that taking a 2-generation approach is important. Families may customarily live in multigenerational family units, and this is a cultural norm for some. The opioid crisis has produced many kinship and grand-families, emphasizing the need for multigenerational care because both children and caregivers have suffered traumatic losses and may be influenced by their own trauma histories.²¹⁰ Addressing how adversity experienced by a caregiver in childhood may affect their parenting and resilience can have profound effects on a child's health and outcomes. This approach can include asking these questions in engagement, surveillance, and screening; careful consideration of how the provider or practice can and will respond to elicited issues is important before integrating this into practice flow.

Community Partnerships

Pediatric offices can develop methods to coordinate trauma-related care with schools, child care, early educators, courts, legal supports, child welfare services, and other community partners (see policy statement¹⁹).

Staff and Provider Support

Addressing the trauma experiences of others can have significant consequences for health providers and staff. Per the National Child Traumatic Stress Network, STS is the emotional distress that results

when an individual hears about the first-hand trauma experiences of another.¹³⁶ The essential act of listening to trauma stories may take an emotional toll that compromises professional functioning and diminishes quality of life. Burnout is a syndrome characterized by a high degree of emotional exhaustion and depersonalization (ie, cynicism) and a low sense of personal accomplishment from work. Burnout refers more to general occupational stress and is not used to describe the effects of indirect trauma exposure specifically.¹³⁶ At least one meta-analysis concluded that job burnout contributes to, or at least increases the risk of, STS.¹⁴² Recent surveys of medical students and residents reveal a high rate of depression (Patient Health Questionnaire-9 score >10) of 25% to 30%.^{139,211} Some data indicate that more than 50% of the physician workforce in the United States suffers from burnout related to their profession.²¹²⁻²¹⁴ For the individual physician, burnout can result in increased rates of apathy, depression, substance abuse, and suicide and can affect personal relationships.^{139,212} STS similarly affects providers, although it is more often discussed in the mental health and child welfare literature rather than the medical literature.¹⁴⁴

Detailed discussion of the response to burnout and STS is beyond the scope of this clinical report. However, effective TIC includes recognition of the effect of indirect trauma exposure on the workforce and safeguards to protect those caring for children and caregivers.^{136,143} Acknowledgment that these are issues and providing resources to address them, with attention to leadership and supervision, have been cited as the most important first steps.^{143,212,215} For both burnout and STS, support from the immediate supervisor and

organizational leadership have been demonstrated to be effective ways to combat the effects of trauma.^{143,209} Team-based care, efficiencies in practice, and opportunities to share successes and frustrations with peers can all be helpful.^{216–218} Promoting self-care remains an important part of TIC, with adequate time for rest, distance from the office or hospital, exercise, healthy diet, and prayer, meditation, or mindfulness shown to reduce symptoms of burnout and STS.^{143,219,220} Such interventions are integral to developing and sustaining a trauma-informed practice and include all members of the health care team.

SUMMARY

TIC recognizes that exposure to adversities is common to many, if not most, children and that the developmental, behavioral, and health consequences can be profound and long lasting. Pediatric clinicians with an understanding of the physiology of both resilience and trauma are in a position to promote resilience, recognize and respond to traumas, and promote recovery.

Key Points

1. TIC is fundamentally relational health care, the ability to form and maintain SSNRs. Pediatric clinicians are well positioned to use a 2-generation approach, evaluate attachment relationships, and harness these attachments to encourage the caregiver's role in promoting regulation and resilience.
2. Providing TIC is achieved through common pediatric practices, starting with engagement and providing a safe setting for patients and families. Obtaining history, using surveillance or screening tools appropriate to the pediatric setting and clinical need, and effecting a response involving the pediatric provider and other

community resources is consistent with addressing most health-related issues.

3. Trauma symptoms can vary, from changes in eating and sleeping to severe physical and mental health effects requiring extensive treatment. Individual differences in trauma symptoms relate to the interplay of exposures and buffering from SSNRs as well as genetic variations impacted by the early environment (biological differential sensitivity to context).
4. Treatment can begin in the office setting with psychoeducation and brief guidance for caregivers. Facilitating linkages to community resources for families to programs that promote positive parenting skills, regulation, and self-efficacy; address the SDoHs (poverty, housing, food insecurity, etc); or provide EBT further supports those at risk and can effectively treat those who are symptomatic.
5. Integrating this relational model of care to prevent and mitigate the impact of trauma so that all members of the care team feel supported and valued is integral to TIC. Addressing safety and supporting relationships that promote affiliative responses, decrease stress responses, and promote building resilience are principles of TIC for children, caregivers, and health care personnel.

Lead Authors

Heather Forkey, MD, FAAP
 Moira Szilagyi, MD, PhD, FAAP
 Erin T. Kelly, MD, FAAP, FACP
 James Duffee, MD, MPH, FAAP

Council on Foster Care, Adoption, and Kinship Care Executive Committee, 2019–2021

Sarah H. Springer, MD, FAAP, Chairperson
 Moira Szilagyi, MD, PhD, FAAP, Immediate Past Chairperson

Heather Forkey, MD, FAAP
 Kristine Fortin, MD, MPH, FAAP
 Mary Booth Vaden Greiner, MD, MS, FAAP
 Todd J. Ochs, MD, FAAP
 Anu N. Partap, MD, MPH, FAAP
 Linda Davidson Sagor, MD, MPH, FAAP
 Deborah L. Shropshire, MD, FAAP
 Jonathan D. Thackeray, MD, FAAP
 Douglas Waite, MD, FAAP
 Lisa Weber Zetley, MD, FAAP

Liaisons

Jeremy Harvey – *Foster Care Alumni of America*
 Wynne Shepard Morgan, MD – *American Academy of Child and Adolescent Psychiatry*
 Camille Robinson, MD, FAAP – *Section on Pediatric Trainees*

Staff

Tammy Piazza Hurley
 Mary Crane, PhD, LSW
 Müge Chavdar, MPH

Council on Community Pediatrics Executive Committee, 2019–2021

James Duffee, MD, MPH, FAAP, Chairperson
 Kimberly G. Montez, MD, MPH, FAAP, Vice Chairperson
 Kimberley J. Dillely, MD, MPH, FAAP
 Andrea E. Green, MD, FAAP
 Joyce Javier, MD, MPH, MS, FAAP
 Madhulika Mathur, MD, MPH, FAAP
 Gerri Mattson, MD, FAAP
 Kimberly Montez, MD, MPH, FAAP
 Jacqueline L. Nelson, MD, FAAP
 Mikah Owen, MD, MPH, FAAP
 Kenya Parks, MD, MPH, FAAP
 Christopher B. Peltier, MD, FAAP

Liaisons

Donene Feist – *Family Voices*
 Rachel Nash, MD, MPH, MD – *Section on Pediatric Trainees*
 Judith Thierry, DO, MPH, FAAP – *Committee on Native American Child Health*

Staff

Dana Bennett-Tejes, MA, MNM

Council on Child Abuse and Neglect Executive Committee, 2019–2021

Suzanne B. Haney, MD, MS, FAAP,
Chairperson

Andrew P. Sirotiak, MD, FAAP,
Immediate Past Chairperson

Andrea Gottsegen Asnes, MD, FAAP

Amy R. Gavril, MD, MSCI, FAAP

Amanda Bird Hoffert Gilmartin, MD,
FAAP

Rebecca Greenlee Girardet, MD,
FAAP

Nancy D. Heavilin, MD, FAAP

Sheila M. Idzerda, MD, FAAP

Antoinette Laskey, MD, MPH, MBA,
FAAP

Lori A. Legano, MD, FAAP

Stephen A. Messner, MD, FAAP

Bethany A. Mohr, MD, FAAP

Shalon Marie Nienow, MD, FAAP

Norell Rosado, MD, FAAP

Liaisons

Heather Forkey, MD, FAAP – *Council on
Foster Care, Adoption, and Kinship Care*
Brooks Keeshin, MD, FAAP – *American
Academy of Child and Adolescent
Psychiatry*

Jennifer Matjasko, PhD – *Centers for
Disease Control and Prevention*

Anish Raj, MD – *Section on Pediatric
Trainees*

Elaine Stedt, MSW, ACSW – *Adminis-
tration for Children, Youth and Fam-
ilies, Office on Child Abuse and Neglect*

Staff

Tammy Piazza Hurley

Müge Chavdar, MPH

Committee on Psychosocial Aspects of Child and Family Health, 2019–2020

Arthur Lavin, MD, FAAP,
Chairperson

George L. Askew, MD, FAAP

Rebecca Baum, MD, FAAP

Evelyn Berger-Jenkins, MD, FAAP

Tiffani J. Johnson, MD, MSc, FAAP

Douglas Jutte, MD, MPH, FAAP

Arwa Abdulhaq Nasir, MBBS, MSc,
MPH, FAAP

Liaisons

Sharon Berry, PhD, ABPP, LP – *Soci-
ety of Pediatric Psychology*
Edward R. Christophersen, PhD,
FAAP – *Society of Pediatric
Psychology*

Kathleen Hobson Davis, LSW – *Fam-
ily Liaison*

Norah L. Johnson, PhD, RN,
CPNP-BC – *National Association of
Pediatric Nurse Practitioners*

Abigail Boden Schlesinger, MD –
*American Academy of Child and Ado-
lescent Psychiatry*

Rachel Segal, MD, FAAP – *Section on
Pediatric Trainees*

Amy Starin, PhD, LCSW – *National
Association of Social Workers*

Staff

Carolyn Lullo McCarty, PhD

ABBREVIATIONS

ACE: adverse childhood
experience

DTD: developmental trauma
disorder

EBT: evidence-based treatment

PFA: Psychological First Aid

PTSD: posttraumatic stress
disorder

SDoH: social determinant of
health

SSNR: safe, stable, and nurturing
relationship

STS: secondary traumatic stress

TIC: trauma-informed care

Copyright © 2021 by the American Academy of Pediatrics

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

REFERENCES

1. Copeland WE, Keeler G, Angold A, Costello EJ. Traumatic events and post-traumatic stress in childhood. *Arch Gen Psychiatry*. 2007;64(5):577–584
2. Schilling EA, Aseltine RH Jr, Gore S. Adverse childhood experiences and mental health in young adults: a longitudinal survey. *BMC Public Health*. 2007;7:30
3. Burke NJ, Hellman JL, Scott BG, Weems CF, Carrion VG. The impact of adverse childhood experiences on an urban pediatric population. *Child Abuse Negl*. 2011;35(6):408–413
4. Lipschitz DS, Rasmussen AM, Anyan W, Cromwell P, Southwick SM. Clinical and functional correlates of posttraumatic stress disorder in urban adolescent girls at a primary care clinic. *J Am Acad Child Adolesc Psychiatry*. 2000;39(9):1104–1111
5. Suicide Prevention Resource Center; Substance Abuse and Mental Health Services Administration. Fact sheet: trauma among American Indians and Alaska natives. Missoula, MT: National Native Children's Trauma Center; 2016. Available at: <https://www.sprc.org/resources-programs/fact-sheet-trauma-among-american-indians-alaska-natives>. Accessed January 11, 2021
6. Miller KK, Brown CR, Shramko M, Svetaz MV. Applying trauma-informed practices to the care of refugee and immigrant youth: 10 clinical pearls. *Children (Basel)*. 2019;6(8):94

7. Bethell C, Davis MB, Gombojav N, Stumbo S, Powers K. Issue brief: a national and across-state profile on adverse childhood experiences among children and possibilities to heal and thrive. 2017. Available at: https://www.cahmi.org/wp-content/uploads/2018/05/aces_brief_final.pdf. Accessed January 11, 2021
8. Ellis WR, Dietz WH. A new framework for addressing adverse childhood and community experiences: the building community resilience model. *Acad Pediatr*. 2017;17(7S):S86–S93
9. Cronholm PF, Forke CM, Wade R, et al. Adverse childhood experiences: expanding the concept of adversity. *Am J Prev Med*. 2015;49(3):354–361
10. Garner AS, Shonkoff JP; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. *Pediatrics*. 2012;129(1):e224–e231
11. American Academy of Pediatrics. *Adverse Childhood Experiences and the Lifelong Consequences of Trauma*. Elk Grove Village, IL: American Academy of Pediatrics; 2014. Available at: https://www.aap.org/en-us/documents/ttb_aces_consequences.pdf. Accessed January 11, 2021
12. Anda RF, Felitti VJ, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci*. 2006;256(3):174–186
13. Heim C, Shugart M, Craighead WE, Nemeroff CB. Neurobiological and psychiatric consequences of child abuse and neglect. *Dev Psychobiol*. 2010;52(7):671–690
14. Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1):e232–e246
15. Marsac ML, Kassam-Adams N, Hildenbrand AK, et al. Implementing a trauma-informed approach in pediatric health care networks. *JAMA Pediatr*. 2016;170(1):70–77
16. Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014
17. Stein REK, Storfer-Isser A, Kerker BD, et al. Beyond ADHD: how well are we doing? *Acad Pediatr*. 2016;16(2):115–121
18. Horwitz SM, Storfer-Isser A, Kerker BD, et al. Barriers to the identification and management of psychosocial problems: changes from 2004 to 2013. *Acad Pediatr*. 2015;15(6):613–620
19. Duffee J, Szilagyi M, Forkey H, Kelly ET; American Academy of Pediatrics, Council on Community Pediatrics, Council on Foster Care, Adoption, and Kinship Care, Council on Child Abuse and Neglect, Committee on Psychosocial Aspects of Child and Family Health. Policy statement: trauma-informed care in child health systems. *Pediatrics*. 2021;148(2):e2021052579
20. National Child Traumatic Stress Network. *The 12 Core Concepts: Concepts for Understanding Traumatic Stress Responses in Children and Families*. Los Angeles, CA: National Child Traumatic Stress Network; 2007. Available at: <https://www.nctsn.org/resources/12-core-concepts-concepts-understanding-traumatic-stress-responses-children-and-families>. Accessed January 11, 2021
21. Houtepen LC, Vinkers CH, Carrillo-Roa T, et al. Genome-wide DNA methylation levels and altered cortisol stress reactivity following childhood trauma in humans. *Nat Commun*. 2016;7:10967
22. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245–258
23. Flynn AB, Fothergill KE, Wilcox HC, et al. Primary care interventions to prevent or treat traumatic stress in childhood: a systematic review. *Acad Pediatr*. 2015;15(5):480–492
24. Centers for Disease Control and Prevention. Essentials for childhood: creating Safe, stable, nurturing relationships and environments. Available at: <https://www.cdc.gov/violenceprevention/childabuseandneglect/essentials.html>. Accessed January 11, 2021
25. Garner AS, Forkey H, Szilagyi M. Translating developmental science to address childhood adversity. *Acad Pediatr*. 2015;15(5):493–502
26. Lahey BB, Rathouz PJ, Lee SS, et al. Interactions between early parenting and a polymorphism of the child's dopamine transporter gene in predicting future child conduct disorder symptoms. *J Abnorm Psychol*. 2011;120(1):33–45
27. Whittle S, Simmons JG, Dennison M, et al. Positive parenting predicts the development of adolescent brain structure: a longitudinal study. *Dev Cogn Neurosci*. 2014;8:7–17
28. McEwen BS, Gianaros PJ. Central role of the brain in stress and adaptation: links to socioeconomic status, health, and disease. *Ann N Y Acad Sci*. 2010;1186:190–222
29. Merrick MT, Ford DC, Ports KA, et al. Vital Signs: estimated proportion of adult health problems attributable to adverse childhood experiences and implications for prevention - 25 states, 2015–2017. *MMWR Morb Mortal Wkly Rep*. 2019;68(44):999–1005
30. Center for the Developing Child. ACEs and toxic stress: frequently asked questions. Available at: <https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/>. Accessed January 11, 2021
31. McHugo GJ, Kammerer N, Jackson EW, et al. Women, co-occurring disorders, and violence study: evaluation design and study population. *J Subst Abuse Treat*. 2005;28(2):91–107
32. Bethell C, Jones J, Gombojav N, Linkenbach J, Sege R. Positive childhood experiences and adult mental and relational health in a statewide sample: associations across adverse childhood experiences levels. *JAMA Pediatr*. 2019;173(11):e193007

33. Bethell CD, Gombojav N, Whitaker RC. Family resilience and connection promote flourishing among US children, even amid adversity. *Health Aff (Millwood)*. 2019;38(5):729–737
34. Zeanah P, Burstein K, Cartier J. Addressing Adverse childhood experiences: it's all about relationships. *Societies*. 2018;8(4):115
35. US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. *Child Maltreatment*. Washington, DC: US Department of Health and Human Services; 2017. Available at: www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment. Accessed January 11, 2021
36. Child Welfare Information Gateway. *Foster Care Statistics 2019*. Washington, DC: US Department of Health and Human Services, Children's Bureau; 2019. Available at: <https://www.acf.hhs.gov/cb/report/afcars-report-27>. Accessed January 11, 2021
37. Burgess AL, Borowsky IW. Health and home environments of caregivers of children investigated by child protective services. *Pediatrics*. 2010;125(2):273–281
38. Campbell KA, Thomas AM, Cook LJ, Keenan HT. Longitudinal experiences of children remaining at home after a first-time investigation for suspected maltreatment. *J Pediatr*. 2012;161(2):340–347
39. Horwitz SM, Hurlburt MS, Cohen SD, Zhang J, Landsverk J. Predictors of placement for children who initially remained in their homes after an investigation for abuse or neglect. *Child Abuse Negl*. 2011;35(3):188–198
40. Perez D, Sribney WM, Rodríguez MA. Perceived discrimination and self-reported quality of care among Latinos in the United States. *J Gen Intern Med*. 2009;24(Suppl 3):548–554
41. Wood LCN. Impact of punitive immigration policies, parent-child separation and child detention on the mental health and development of children. *BMJ Paediatr Open*. 2018;2(1):e000338
42. Johnson SB, Riis JL, Noble KG. State of the art review: poverty and the developing brain. *Pediatrics*. 2016;137(4):e20153075
43. National Advisory Committee on Rural Health and Human Services. *Exploring the Rural Context For Adverse Childhood Experiences: Policy Brief and Recommendations*. Washington, DC: US Department of Health and Human Services; 2018
44. Evans GW, English K. The environment of poverty: multiple stressor exposure, psychophysiological stress, and socioemotional adjustment. *Child Dev*. 2002;73(4):1238–1248
45. Hackman DA, Farah MJ. Socioeconomic status and the developing brain. *Trends Cogn Sci*. 2009;13(2):65–73
46. Trent M, Dooley DG, Doug e J; Section on Adolescent Health; Council on Community Pediatrics; Committee on Adolescence. Council on Community Pediatrics; Committee on Adolescence. The impact of racism on child and adolescent health. *Pediatrics*. 2019;144(2):e20191765
47. Heard-Garris NJ, Cale M, Camaj L, Hamati MC, Dominguez TP. Transmitting trauma: a systematic review of vicarious racism and child health. *Soc Sci Med*. 2018;199:230–240
48. Mohatt NV, Thompson AB, Thai ND, Tebes JK. Historical trauma as public narrative: a conceptual review of how history impacts present-day health. *Soc Sci Med*. 2014;106:128–136
49. Wade R Jr, Shea JA, Rubin D, Wood J. Adverse childhood experiences of low-income urban youth. *Pediatrics*. 2014;134(1):e13–e20
50. Nixon CL. Current perspectives: the impact of cyberbullying on adolescent health. *Adolesc Health Med Ther*. 2014;5:143–158
51. Finkelhor D, Turner HA, Shattuck A, Hamby SL. Violence, crime, and abuse exposure in a national sample of children and youth: an update. [published correction appears in *JAMA Pediatr*. 2014;168(3):286]. *JAMA Pediatr*. 2013;167(7):614–621
52. Roberts AL, Austin SB, Corliss HL, Vander-morris AK, Koenen KC. Pervasive trauma exposure among US sexual orientation minority adults and risk of posttraumatic stress disorder. *Am J Public Health*. 2010;100(12):2433–2441
53. Carroll G. Mundane extreme environmental stress and African American families: a case for recognizing different realities. *J Comp Fam Stud*. 1998;29(2):271–284
54. Huynh VW. Ethnic microaggressions and the depressive and somatic symptoms of Latino and Asian American adolescents. *J Youth Adolesc*. 2012;41(7):831–846
55. Siegel BS, Davis BE; Committee on Psychosocial Aspects of Child and Family Health and Section on Uniformed Services. Health and mental health needs of children in US military families. *Pediatrics*. 2013;131(6):e2002–e2015
56. Marsac ML, Kassam-Adams N, Delahanty DL, Widaman KF, Barakat LP. Posttraumatic stress following acute medical trauma in children: a proposed model of bio-psycho-social processes during the peri-trauma period. *Clin Child Fam Psychol Rev*. 2014;17(4):399–411
57. Brosbe MS, Hoefling K, Faust J. Predicting posttraumatic stress following pediatric injury: a systematic review. *J Pediatr Psychol*. 2011;36(6):718–729
58. Garner AS. Thinking developmentally: the next evolution in models of health. *J Dev Behav Pediatr*. 2016;37(7):579–584
59. Bretherton I. The origins of attachment theory: John Bowlby and Mary Ainsworth. *Dev Psychol*. 1992;28(5):759–775
60. Feldman R. The adaptive human parental brain: implications for children's social development. *Trends Neurosci*. 2015;38(6):387–399
61. Hughes DA, Baylin J. *The Neurobiology of Attachment-Focused Therapy: Enhancing Connection and Trust in the Treatment of Children and Adolescents*. New York, NY: W.W. Norton and Co; 2016
62. Allen JG. *Restoring Mentalizing in Attachment Relationships: Treating Trauma with Plain Old Therapy*. Arlington, VA: American Psychiatric Publishing; 2013
63. Cantor P, Osher D, Berg J, Steyer L, Rose T. Malleability, plasticity, and individuality: how children learn and develop in context. *Appl Dev Sci*. 2019;23(4):307–337
64. Ainsworth MD. Attachments beyond infancy. *Am Psychol*. 1989;44(4):709–716

65. Perry RE, Blair C, Sullivan RM. Neurobiology of infant attachment: attachment despite adversity and parental programming of emotionality. *Curr Opin Psychol*. 2017;17:1–6
66. Hoghugh M, Speight AN. Good enough parenting for all children—a strategy for a healthier society. *Arch Dis Child*. 1998;78(4):293–296
67. Winnicott DW. *The Maturation Process and the Facilitative Environment*. New York, NY: International Universities Press; 1965
68. Porges SW. Social engagement and attachment: a phylogenetic perspective. *Ann N Y Acad Sci*. 2003;1008:31–47
69. Benoit D. Infant-parent attachment: definition, types, antecedents, measurement and outcome. *Paediatr Child Health*. 2004;9(8):541–545
70. Olf M, Frijling JL, Kubzansky LD, et al. The role of oxytocin in social bonding, stress regulation and mental health: an update on the moderating effects of context and interindividual differences. *Psychoneuroendocrinology*. 2013;38(9):1883–1894
71. Masten AS. Ordinary magic. Resilience processes in development. *Am Psychol*. 2001;56(3):227–238
72. Sege RD, Harper Browne C. Responding to ACEs With HOPE: health outcomes from positive experiences. *Acad Pediatr*. 2017;17(7S):S79–S85
73. Garner A, Yogman M; American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health, Section on Developmental and Behavioral Pediatrics, Council on Early Childhood. Preventing childhood toxic stress: partnering with families and communities to promote relational health. *Pediatrics*. 2021;148(2):e2021052582
74. Children's Hospital of Philadelphia Research Institute. Basics of trauma-informed care. Available at: <https://www.healthcaretoolbox.org/>. Accessed January 11, 2021
75. Brymer M, Jacobs A, Layne C, et al. *Psychological First Aid Field Operations Guide*. 2nd ed. Los Angeles, CA: National Child Traumatic Stress Network and National Center for Post-traumatic Stress Disorder; 2006
76. Finkelhor D. Screening for adverse childhood experiences (ACEs): cautions and suggestions. *Child Abuse Negl*. 2018;85:174–179
77. Flaherty E, Legano L, Idzerda S; Council on Child Abuse and Neglect. Ongoing pediatric health care for the child who has been maltreated. *Pediatrics*. 2019;143(4):e20190284
78. Flaherty EG, Stirling J Jr; American Academy of Pediatrics. Committee on Child Abuse and Neglect. Clinical report—the pediatrician's role in child maltreatment prevention. *Pediatrics*. 2010;126(4):833–841
79. Schnierle J, Christian-Brathwaite N, Louisias M. Implicit bias: what every pediatrician should know about the effect of bias on health and future directions. *Curr Probl Pediatr Adolesc Health Care*. 2019;49(2):34–44
80. Johnson SB, Riley AW, Granger DA, Riis J. The science of early life toxic stress for pediatric practice and advocacy. *Pediatrics*. 2013;131(2):319–327
81. Dantzer R, O'Connor JC, Freund GG, Johnson RW, Kelley KW. From inflammation to sickness and depression: when the immune system subjugates the brain. *Nat Rev Neurosci*. 2008;9(1):46–56
82. Jonson-Reid M, Wideman E. Trauma and very young children. *Child Adolesc Psychiatr Clin N Am*. 2017;26(3):477–490
83. Cook A, Spinazzola J, Ford J, et al. Complex trauma in children and adolescents. *Psychiatr Ann*. 2005;35(5):390–398
84. Substance Abuse and Mental Health Services Administration. *Recognizing and Treating Child Traumatic Stress*. Washington, DC: Substance Abuse and Mental Health Services Administration; 2004. Available at: <https://www.samhsa.gov/child-trauma/recognizing-and-treating-child-traumatic-stress#signs>. Accessed January 11, 2021
85. Cohen JA, Kelleher KJ, Mannarino AP. Identifying, treating, and referring traumatized children: the role of pediatric providers. *Arch Pediatr Adolesc Med*. 2008;162(5):447–452
86. Siegfried CB, Blackhear K; National Child Traumatic Stress Network and National Resource Center on ADHD. *Is it ADHD or Child Traumatic Stress? A Guide for Clinicians*. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress; 2016
87. Keeshin B, Forkey HC, Fouras G, MacMillan HL; American Academy of Pediatrics, Council on Child Abuse and Neglect, Council on Foster Care, Adoption, and Kinship Care, American Academy of Child and Adolescent Psychiatry, Committee on Child Maltreatment and Violence, Committee on Adoption and Foster Care. Children exposed to maltreatment: assessment and the role of psychotropic medication. *Pediatrics*. 2020;145(2):e20193751
88. Blaustein M, Kinniburgh K. *Treating Traumatic Stress in Children and Adolescents: How to Foster Resilience Through Attachment, Self-Regulation and Competency*, 2nd ed. New York, NY: The Guilford Press; 2019
89. De Bellis MD, Zisk A. The biological effects of childhood trauma. *Child Adolesc Psychiatr Clin N Am*. 2014;23(2):185–222, vii
90. Bremner JD. Traumatic stress: effects on the brain. *Dialogues Clin Neurosci*. 2006;8(4):445–461
91. Lupien SJ, McEwen BS, Gunnar MR, Heim C. Effects of stress throughout the lifespan on the brain, behaviour and cognition. *Nat Rev Neurosci*. 2009;10(6):434–445
92. Penza KM, Heim C, Nemeroff CB. Neurobiological effects of childhood abuse: implications for the pathophysiology of depression and anxiety. *Arch Women Ment Health*. 2003;6(1):15–22
93. Teicher MH, Samson JA, Anderson CM, Ohashi K. The effects of childhood maltreatment on brain structure, function and connectivity. *Nat Rev Neurosci*. 2016;17(10):652–666
94. Miller LE. Perceived threat in childhood: a review of research and implications for children living in violent households. *Trauma Violence Abuse*. 2015;16(2):153–168
95. Teicher MH, Samson JA. Childhood maltreatment and psychopathology: a case for ecophenotypic variants as clinically and neurobiologically distinct subtypes. *Am J Psychiatry*. 2013;170(10):1114–1133

96. Birn RM, Roeber BJ, Pollak SD. Early childhood stress exposure, reward pathways, and adult decision making. *Proc Natl Acad Sci USA*. 2017;114(51):13549–13554
97. Syed SA, Nemeroff CB. Early life stress, mood, and anxiety disorders. *Chronic Stress (Thousand Oaks)*. 2017;1:2470547017694461
98. Ringeisen H, Casanueva C, Urato M, Cross T. Special health care needs among children in the child welfare system. *Pediatrics*. 2008;122(1):e232–e241
99. Clougherty JE, Levy JI, Kubzansky LD, et al. Synergistic effects of traffic-related air pollution and exposure to violence on urban asthma etiology. *Environ Health Perspect*. 2007;115(8):1140–1146
100. Centers for Disease Control and Prevention. Developmental monitoring and screening for health professionals. Available at: <https://www.cdc.gov/ncbddd/childdevelopment/screening-hcp.html>. Accessed January 11, 2021
101. Klein D, Goldenring JM, Adelman WP. HEADSSS 3.0: the psychosocial interview for adolescents updated for a new century fueled by media. *Contemp Pediatr*. 2014;31(1):16–28
102. Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. *Contemp Pediatr*. 2004;21(1):64–90
103. Conn AM, Szilagyi MA, Jee SH, Manly JT, Briggs R, Szilagyi PG. Parental perspectives of screening for adverse childhood experiences in pediatric primary care. *Fam Syst Health*. 2018;36(1):62–72
104. Colvin JD, Bettenhausen JL, Anderson-Carpenter KD, Collie-Akers V, Chung PJ. Caregiver opinion of in-hospital screening for unmet social needs by pediatric residents. *Acad Pediatr*. 2016;16(2):161–167
105. Wissow L, Anthony B, Brown J, et al. A common factors approach to improving the mental health capacity of pediatric primary care. *Adm Policy Ment Health*. 2008;35(4):305–318
106. Ginsburg K. Viewing our patients through a positive lens. *Contemp Pediatr*. 2007;24(1):65–76
107. Traub F, Boynton-Jarrett R. Modifiable resilience factors to childhood adversity for clinical pediatric practice. *Pediatrics*. 2017;139(5):e20162569
108. Greene R, Winkler J. Collaborative and Proactive Solutions (CPS): a review of research findings in families, schools, and treatment facilities. *Clin Child Fam Psychol Rev*. 2019;22(4):549–561
109. Lipkin PH, Macias MM; Council on Children With Disabilities, Section on Developmental and Behavioral Pediatrics. Promoting optimal development: identifying infants and young children with developmental disorders through developmental surveillance and screening. *Pediatrics*. 2020;145(1):e20193449
110. Squires J, Potter L, Bricker D. *The ASQ User's Guide*, 3rd ed. Baltimore, MD: Paul H. Brookes Publishing Co; 2009
111. Jellinek MS, Murphy JM, Little M, Pagano ME, Comer DM, Kelleher KJ. Use of the Pediatric Symptom Checklist to screen for psychosocial problems in pediatric primary care: a national feasibility study. *Arch Pediatr Adolesc Med*. 1999;153(3):254–260
112. Stone LL, Otten R, Engels RCME, Vermulst AA, Janssens JM. Psychometric properties of the parent and teacher versions of the strengths and difficulties questionnaire for 4- to 12-year-olds: a review. *Clin Child Fam Psychol Rev*. 2010;13(3):254–274
113. Richardson LP, McCauley E, Grossman DC, et al. Evaluation of the Patient Health Questionnaire-9 Item for detecting major depression among adolescents. *Pediatrics*. 2010;126(6):1117–1123
114. Earls MF, Yogman MW, Mattson G, Rafferty J; Committee on Psychosocial Aspects of Child and Family Health. Incorporating recognition and management of perinatal depression into pediatric practice. *Pediatrics*. 2019;143(1):e20183259
115. Rolon-Arroyo B, Oosterhoff B, Layne CM, Steinberg AM, Pynoos RS, Kaplow JB. The UCLA PTSD Reaction Index for DSM-5 Brief Form: a screening tool for trauma-exposed youths. *J Am Acad Child Adolesc Psychiatry*. 2020;59(3):434–443
116. Kazak A, Schneider S, Didonato S, Pai ALH. Family psychosocial risk screening guided by the Pediatric Preventative Psychosocial Health Model (PPPHM) using the Psychosocial Assessment Tool (PAT). *Acta Oncol*. 2015;54(5):574–580
117. Kazak AE, Hwang WT, Chen FF, et al. Screening for family psychosocial risk in pediatric cancer: validation of the Psychosocial Assessment Tool (PAT) Version 3. *J Pediatr Psychol*. 2018;43(7):737–748
118. Keeshin B, Byrne K, Thorn B, Shepard L. Screening for trauma in pediatric primary care. *Curr Psychiatry Rep*. 2020;22(11):60
119. Bethell CD, Carle A, Hudziak J, et al. Methods to assess adverse childhood experiences of children and families: toward approaches to promote child well-being in policy and practice. *Acad Pediatr*. 2017;17(7S):S51–S69
120. Purewal SK, Bucci M, Gutiérrez Wang L, et al. Screening for adverse childhood experiences (ACEs) in an integrated pediatric care model. *Zero Three*. 2016;36(3):10–17
121. Colvin JD, Bettenhausen JL, Anderson-Carpenter KD, et al. Multiple behavior change intervention to improve detection of unmet social needs and resulting resource referrals. *Acad Pediatr*. 2016;16(2):168–174
122. Shah AN, Beck AF, Sucharew HJ, et al; H2O Study Group. Parental adverse childhood experiences and resilience on coping after discharge. *Pediatrics*. 2018;141(4):e20172127
123. Folger AT, Eismann EA, Stephenson NB, et al. Parental adverse childhood experiences and offspring development at 2 years of age. *Pediatrics*. 2018;141(4):e20172826
124. Schickedanz A, Halfon N, Sastry N, Chung PJ. Parents' adverse childhood experiences and their children's behavioral health problems. *Pediatrics*. 2018;142(2):e20180023
125. Lê-Scherban F, Wang X, Boyle-Steed KH, Pachter LM. Intergenerational associations of parent adverse childhood experiences and child health outcomes. *Pediatrics*. 2018;141(6):e20174274
126. Connor KM, Davidson JRT. Development of a new resilience scale: the Connor-Davidson Resilience Scale (CD-

- RISC). *Depress Anxiety*. 2003;18(2): 76–82
127. Smith BW, Dalen J, Wiggins K, Tooley E, Christopher P, Bernard J. The brief resilience scale: assessing the ability to bounce back. *Int J Behav Med*. 2008;15(3):194–200
 128. Windle G, Bennett KM, Noyes J. A methodological review of resilience measurement scales. *Health Qual Life Outcomes*. 2011;9:8
 129. Anda RF, Porter LE, Brown DW. Inside the Adverse Childhood Experience Score: strengths, limitations, and misapplications. *Am J Prev Med*. 2020;59(2):293–295
 130. Dube SR. Continuing conversations about adverse childhood experiences (ACEs) screening: a public health perspective. *Child Abuse Negl*. 2018;85: 180–184
 131. Shonkoff JP. Capitalizing on advances in science to reduce the health consequences of early childhood adversity. *JAMA Pediatr*. 2016;170(10):1003–1007
 132. Boyce WT, Levitt P, Martinez FD, McEwen BS, Shonkoff JP. Genes, environments and time: the biology of adversity and resilience. *Pediatrics*. 2020;147(2):e20201651
 133. Shonkoff JP, Boyce WT, Levitt P, Martinez F, McEwen B. Leveraging the biology of adversity and resilience to transform pediatric practice. *Pediatrics*. 2020;147(2):e20193845
 134. Slopen N, McLaughlin KA, Shonkoff JP. Interventions to improve cortisol regulation in children: a systematic review. *Pediatrics*. 2014;133(2):312–326
 135. Le-Niculescu H, Roseberry K, Levey DF, et al. Towards precision medicine for stress disorders: diagnostic biomarkers and targeted drugs. *Mol Psychiatry*. 2020;25(5):918–938
 136. National Child Traumatic Stress Network. *Secondary Traumatic Stress: A Fact Sheet for Child-Serving Professionals*. Los Angeles, CA: National Child Traumatic Stress Network; 2011. Available at: <https://www.nctsn.org/resources/secondary-traumatic-stress-fact-sheet-child-serving-professionals>. Accessed January 11, 2021
 137. Cieslak R, Shoji K, Douglas A, Melville E, Luszczynska A, Benight CC. A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. *Psychol Serv*. 2014;11(1):75–86
 138. Cocker F, Joss N. Compassion fatigue among healthcare, emergency and community service workers: a systematic review. *Int J Environ Res Public Health*. 2016;13(6):618
 139. Dyrbye LN, Thomas MR, Massie FS, et al. Burnout and suicidal ideation among U.S. medical students. *Ann Intern Med*. 2008;149(5):334–341
 140. Oreskovich MR, Shanafelt T, Dyrbye LN, et al. The prevalence of substance use disorders in American physicians. *Am J Addict*. 2015;24(1):30–38
 141. Robins PM, Meltzer L, Zelikovsky N. The experience of secondary traumatic stress upon care providers working within a children's hospital. *J Pediatr Nurs*. 2009;24(4):270–279
 142. Shoji K, Lesnierowska M, Smoktunowicz E, et al. What comes first, job burnout or secondary traumatic stress? Findings from two longitudinal studies from the U.S. and Poland. *PLoS One*. 2015;10(8):e0136730
 143. Sprang G, Craig C, Clark J. Secondary traumatic stress and burnout in child welfare workers: a comparative analysis of occupational distress across professional groups. *Child Welfare*. 2011;90(6):149–168
 144. van Mol MMC, Kompanje EJ, Benoit DD, Bakker J, Nijkamp MD. The prevalence of compassion fatigue and burnout among healthcare professionals in intensive care units: a systematic review. *PLoS One*. 2015;10(8):e0136955
 145. The Center for Victims of Torture. Professional quality of life: elements, theory, and measurement. 2019. Available at: <https://proqol.org/>. Accessed January 11, 2021
 146. Wilson JP, So-Kum Tang CC. *Cross-Cultural Assessment of Psychological Trauma and PTSD*. New York, NY: Springer Publishing; 2007
 147. Flynn JT, Kaelber DC, Baker-Smith CM, et al; Subcommittee on Screening and Management of High Blood Pressure in Children. Clinical practice guideline for screening and management of high blood pressure in children and adolescents. *Pediatrics*. 2017;140(3): e20171904
 148. Gooding HC, Milliren CE, Austin SB, Sheridan MA, McLaughlin KA. Child abuse, resting blood pressure, and blood pressure reactivity to psychosocial stress. *J Pediatr Psychol*. 2016;41(1):5–14
 149. Su S, Wang X, Pollock JS, et al. Adverse childhood experiences and blood pressure trajectories from childhood to young adulthood: the Georgia stress and Heart study. *Circulation*. 2015;131(19):1674–1681
 150. Szilagyi MA, Rosen DS, Rubin D, Zlotnik S; Council on Foster Care, Adoption, and Kinship Care; Committee on Adolescence; Council on Early Childhood. Health care issues for children and adolescents in foster care and kinship care. *Pediatrics*. 2015;136(4): e1142–e1166
 151. Davis L, Barnes AJ, Gross AC, Ryder JR, Schlafer RJ. Adverse childhood experiences and weight status among adolescents. *J Pediatr*. 2019;204: 71–76.e1
 152. Javier JR, Hoffman LR, Shah SI; Pediatric Policy Council. Making the case for ACEs: adverse childhood experiences, obesity, and long-term health. *Pediatr Res*. 2019;86(4):420–422
 153. Purswani P, Marsicak SM, Amankwah EK. Association between cumulative exposure to adverse childhood experiences and childhood obesity. *PLoS One*. 2020;15(9):e0239940
 154. Heerman WJ, Krishnaswami S, Barkin SL, McPheeters M. Adverse family experiences during childhood and adolescent obesity. *Obesity (Silver Spring)*. 2016;24(3):696–702
 155. Exley D, Norman A, Hyland M. Adverse childhood experience and asthma onset: a systematic review. *Eur Respir Rev*. 2015;24(136):299–305
 156. Gilbert LK, Breiding MJ, Merrick MT, et al. Childhood adversity and adult chronic disease: an update from ten states and the District of Columbia, 2010. *Am J Prev Med*. 2015;48(3): 345–349
 157. Heneghan A, Stein RE, Hurlburt MS, et al. Mental health problems in teens investigated by U.S. child welfare

- agencies. *J Adolesc Health*. 2013;52(5): 634–640
158. Ford JD, Grasso D, Greene C, Levine J, Spinazzola J, van der Kolk B. Clinical significance of a proposed developmental trauma disorder diagnosis: results of an international survey of clinicians. *J Clin Psychiatry*. 2013;74(8):841–849
 159. Keeshin BR, Strawn JR. Psychological and pharmacologic treatment of youth with posttraumatic stress disorder: an evidence-based review. *Child Adolesc Psychiatr Clin N Am*. 2014;23(2): 399–411, x
 160. Carrion VG, Weems CF, Reiss AL. Stress predicts brain changes in children: a pilot longitudinal study on youth stress, posttraumatic stress disorder, and the hippocampus. *Pediatrics*. 2007;119(3):509–516
 161. Gunnar M, Quevedo K. The neurobiology of stress and development. *Annu Rev Psychol*. 2007;58:145–173
 162. McDonald MK, Borntrager CF, Rostad W. Measuring trauma: considerations for assessing complex and non-PTSD Criterion A childhood trauma. *J Trauma Dissociation*. 2014;15(2):184–203
 163. van der Kolk B. Developmental trauma disorder. *Psychiatr Ann*. 2005;35(5): 401–409
 164. Ogle CM, Rubin DC, Siegler IC. The impact of the developmental timing of trauma exposure on PTSD symptoms and psychosocial functioning among older adults. *Dev Psychol*. 2013;49(11): 2191–2200
 165. Perry BD, Pollard RA, Blakley TL, Baker WL, Vigilante D. Childhood trauma, the neurobiology of adaptation, and “use-dependent” development of the brain: how “states” become “traits.” *Infant Ment Health J*. 1995;16(4):271–291
 166. Scheeringa MS. Developmental considerations for diagnosing PTSD and acute stress disorder in preschool and school-age children. *Am J Psychiatry*. 2008;165(10):1237–1239
 167. Treisman K. *Working with Relational and Developmental Trauma in Children and Adolescents*. New York, NY: Routledge; 2017
 168. Obradović J, Bush NR, Stampferdahl J, Adler NE, Boyce WT. Biological sensitivity to context: the interactive effects of stress reactivity and family adversity on socioemotional behavior and school readiness. *Child Dev*. 2010;81(1):270–289
 169. Boyce WT, Ellis BJ. Biological sensitivity to context: I. An evolutionary-developmental theory of the origins and functions of stress reactivity. *Dev Psychopathol*. 2005;17(2):271–301
 170. Kennedy E. Orchids and dandelions: how some children are more susceptible to environmental influences for better or worse and the implications for child development. *Clin Child Psychol Psychiatry*. 2013;18(3):319–321
 171. Cole SF, Eisner A, Gregory M, Ristuccia J. *Creating and Advocating for Trauma-Sensitive Schools*. Cambridge, MA: Trauma and Learning Policy Initiative; 2013
 172. Overstreet S, Chafouleas SM. Trauma-informed schools: introduction to the special issue. *School Ment Health*. 2016;8(1):1–6
 173. Allen B, Timmer SG, Urquiza AJ. Parent–child interaction therapy as an attachment-based intervention: theoretical rationale and pilot data with adopted children. *Child Youth Serv Rev*. 2014;47(Part 3):334–341
 174. Camoirano A. Mentalizing makes parenting work: a review about parental reflective functioning and clinical interventions to improve it. *Front Psychol*. 2017;8:14
 175. Zuckerman B, Augustyn M. Books and reading: evidence-based standard of care whose time has come. *Acad Pediatr*. 2011;11(1):11–17
 176. Zuckerman B, Khandekar A. Reach Out and Read: evidence based approach to promoting early child development. *Curr Opin Pediatr*. 2010;22(4):539–544
 177. Needlman R, Toker KH, Dreyer BP, Klass P, Mendelsohn AL. Effectiveness of a primary care intervention to support reading aloud: a multicenter evaluation. *Ambul Pediatr*. 2005;5(4):209–215
 178. Mendelsohn AL, Cates CB, Weisleder A, et al. Reading aloud, play, and social-emotional development. *Pediatrics*. 2018;141(5):e20173393
 179. Shah R, DeFrino D, Kim Y, Atkins M. Sit Down and Play: a preventive primary care-based program to enhance parenting practices. *J Child Fam Stud*. 2017;26(2):540–547
 180. Chang SM, Grantham-McGregor SM, Powell CA, et al. Integrating a parenting intervention with routine primary health care: a cluster randomized trial. *Pediatrics*. 2015;136(2):272–280
 181. Girard LC, Doyle O, Tremblay RE. Maternal warmth and toddler development: support for transactional models in disadvantaged families. *Eur Child Adolesc Psychiatry*. 2017;26(4):497–507
 182. Weisleder A, Cates CB, Dreyer BP, et al. Promotion of positive parenting and prevention of socioemotional disparities. *Pediatrics*. 2016;137(2):e20153239
 183. Shah R, Kennedy S, Clark MD, Bauer SC, Schwartz A. Primary care-based interventions to promote positive parenting behaviors: a meta-analysis. *Pediatrics*. 2016;137(5):e20153393
 184. Perry-Parrish C, Copeland-Linder N, Webb L, Sibinga EMS. Mindfulness-based approaches for children and youth. *Curr Probl Pediatr Adolesc Health Care*. 2016;46(6):172–178
 185. Bauer CCC, Caballero C, Scherer E, et al. Mindfulness training reduces stress and amygdala reactivity to fearful faces in middle-school children. *Behav Neurosci*. 2019;133(6):569–585
 186. Ortiz R, Sibinga EM. The role of mindfulness in reducing the adverse effects of childhood stress and trauma. *Children (Basel)*. 2017;4(3):16
 187. Foa EBKT, Friedman MJ, Cohen JA. *Effective Treatments for Posttraumatic Stress Disorder: Practice Guidelines From the International Society for Traumatic Stress Studies*, 2nd ed. New York, NY: Guilford Press; 2008
 188. Dorsey S, McLaughlin KA, Kerns SEU, et al. Evidence base update for psychosocial treatments for children and adolescents exposed to traumatic events. *J Clin Child Adolesc Psychol*. 2017;46(3):303–330
 189. Sege RD, Amaya-Jackson L; American Academy of Pediatrics Committee on Child Abuse and Neglect, Council on Foster Care, Adoption, and Kinship Care; American Academy of Child and Adolescent Psychiatry Committee on Child Maltreatment and Violence; National Center for Child Traumatic

- Stress. Clinical considerations related to the behavioral manifestations of child maltreatment. *Pediatrics*. 2017;139(4):e20170100
190. Gleason MM, Goldson E, Yogman MW; Council on Early Childhood; Committee on Psychosocial Aspects of Child and Family Health; Section on Developmental and Behavioral Pediatrics. Addressing early childhood emotional and behavioral problems. *Pediatrics*. 2016;138(6):e20163025
 191. Asarnow JR, Rozenman M, Wiblin J, Zeltzer L. Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: a meta-analysis. *JAMA Pediatr*. 2015;169(10):929–937
 192. Dunsmoor JE, Kroes MCW, Li J, Daw ND, Simpson HB, Phelps EA. Role of human ventromedial prefrontal cortex in learning and recall of enhanced extinction. *J Neurosci*. 2019;39(17):3264–3276
 193. Giustino TF, Fitzgerald PJ, Ressler RL, Maren S. Locus coeruleus toggles reciprocal prefrontal firing to reinstate fear. *Proc Natl Acad Sci USA*. 2019;116(17):8570–8575
 194. Sloan DM, Marx BP, Lee DJ, Resick PA. A brief exposure-based treatment vs cognitive processing therapy for post-traumatic stress disorder: a randomized noninferiority clinical trial. *JAMA Psychiatry*. 2018;75(3):233–239
 195. Jones AM, Shealy KM, Reid-Quinones K, et al. Guidelines for establishing a telemental health program to provide evidence-based therapy for trauma-exposed children and families. *Psychol Serv*. 2014;11(4):398–409
 196. Bashshur RL, Shannon GW, Bashshur N, Yellowlees PM. The empirical evidence for telemedicine interventions in mental disorders. *Telemed J E Health*. 2016;22(2):87–113
 197. Conrad R, Rayala H, Diamon R, Busch B, Kramer N. Expanding telemental health in response to the COVID-19 pandemic. 2020. Available at: <https://www.psychiatrytimes.com/view/expanding-telemental-health-response-covid-19-pandemic>. Accessed January 11, 2021
 198. Menschner C, Maul A, Center for Health Care Strategies. *Key Ingredients for Successful Trauma-Informed Care Implementation*. Hamilton, NJ: Center for Health Care Strategies; 2016, Available at <https://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/>. Accessed January 11, 2021
 199. Schulman M, Menschner C. *Laying the Groundwork for Trauma Informed Care*. Hamilton, NJ: Center for Health Care Strategies; 2018. Available at <https://www.chcs.org/resource/laying-groundwork-trauma-informed-care/>. Accessed January 11, 2021
 200. American Academy of Pediatrics. *Trauma Toolbox for Primary Care*. Elk Grove Village, IL: American Academy of Pediatrics; 2014. Available at: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Trauma-Guide.aspx. Accessed January 11, 2021
 201. Pediatric Integrated Care Collaborative. *Improving the Capacity of Primary Care to Serve Children and Families Experiencing Trauma and Chronic Stress: A Toolkit*. Baltimore, MD: Pediatric Integrated Care Collaborative; 2016. Available at: <https://picc.jhu.edu/the-toolkit.html>. Accessed January 11, 2021
 202. Brown SM, Baker CN, Wilcox P. Risking connection trauma training: a pathway toward trauma-informed care in child congregate care settings. *Psychol Trauma*. 2012;4(5):507–515
 203. Bryson SA, Gauvin E, Jamieson A, et al. What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. *Int J Ment Health Syst*. 2017;11:36
 204. Murphy K, Moore KA, Redd Z, Malm K. Trauma-informed child welfare systems and children's well-being: a longitudinal evaluation of KVC's bridging the way home initiative. *Child Youth Serv Rev*. 2017;75:23–34
 205. Schiff DM, Zuckerman B, Hutton E, Genatossio C, Michelson C, Bair-Merritt M. Development and pilot implementation of a trauma-informed care curriculum for pediatric residents. *Acad Pediatr*. 2017;17(7):794–796
 206. Substance Abuse and Mental Health Services Administration. *The Integration of Behavioral Health into Pediatric Primary Care Settings*. Washington, DC: Substance Abuse and Mental Health Services Administration; 2017
 207. Kolko DJ, Perrin E. The integration of behavioral health interventions in children's health care: services, science, and suggestions. *J Clin Child Adolesc Psychol*. 2014;43(2):216–228
 208. Garg A, Toy S, Tripodis Y, Silverstein M, Freeman E. Addressing social determinants of health at well child care visits: a cluster RCT. *Pediatrics*. 2015;135(2):e296–e304
 209. Sun J, Patel F, Rose-Jacobs R, Frank DA, Black MM, Chilton M. Mothers' adverse childhood experiences and their young children's development. *Am J Prev Med*. 2017;53(6):882–891
 210. Feder KA, Letourneau EJ, Brook J. Children in the opioid epidemic: addressing the next generation's public health crisis. *Pediatrics*. 2019;143(1):e20181656
 211. West CP, Tan AD, Habermann TM, Sloan JA, Shanafelt TD. Association of resident fatigue and distress with perceived medical errors. *JAMA*. 2009;302(12):1294–1300
 212. Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc*. 2017;92(1):129–146
 213. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med*. 2012;172(18):1377–1385
 214. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014 [published correction appears in *Mayo Clin Proc*. 2016;91(2):276]. *Mayo Clin Proc*. 2015;90(12):1600–1613
 215. Shanafelt TD, Gorringer G, Menaker R, et al. Impact of organizational leadership on physician burnout and satisfaction. *Mayo Clin Proc*. 2015;90(4):432–440
 216. Shanafelt TD, Dyrbye LN, Sinsky C, et al. Relationship between clerical

- burden and characteristics of the electronic environment with physician burnout and professional satisfaction. *Mayo Clin Proc.* 2016;91(7):836–848
217. Sinsky CA, Willard-Grace R, Schutzbank AM, Sinsky TA, Margolius D, Bodenheimer T. In search of joy in practice: a report of 23 high-functioning primary care practices. *Ann Fam Med.* 2013;11(3):272–278
218. Wallace JE, Lemaire J. On physician well being-you'll get by with a little help from your friends. *Soc Sci Med.* 2007;64(12):2565–2577
219. Horn DJ, Johnston CB. Burnout and self care for palliative care practitioners. *Med Clin North Am.* 2020;104(3):561–572
220. Ofei-Dodoo S, Cleland-Leighton A, Nilssen K, Cloward JL, Casey E. Impact of a mindfulness-based, workplace group yoga intervention on burnout, self-care, and compassion in health care professionals: a pilot study. *J Occup Environ Med.* 2020;62(8):581–587
221. Forkey H, Griffin J, Szilagyi M. *Childhood Trauma and Resilience: A Practical Guide.* Itasca, IL: American Academy of Pediatrics; 2021
222. Roelofs K. Freeze for action: neurobiological mechanisms in animal and human freezing. *Philos Trans R Soc Lond B Biol Sci.* 2017;372(1718):20160206
223. Shonkoff JP, Boyce WT, McEwen BS. Neuroscience, molecular biology, and the childhood roots of health disparities: building a new framework for health promotion and disease prevention. *JAMA.* 2009;301(21):2252–2259
224. Taylor SE, Klein LC, Lewis BP, Gruenewald TL, Gurung RA, Updegraff JA. Biobehavioral responses to stress in females: tend-and-befriend, not fight-or-flight. *Psychol Rev.* 2000;107(3):411–429
225. Taylor SE. Tend and befriend: biobehavioral bases of affiliation under stress. *Curr Dir Psychol Sci.* 2006;15(6):273–277
226. Bartz JA, Zaki J, Bolger N, Ochsner KN. Social effects of oxytocin in humans: context and person matter. *Trends Cogn Sci.* 2011;15(7):301–309
227. Romano A, Tempesta B, Micioni Di Bonaventura MV, Gaetani S. From autism to eating disorders and more: the role of oxytocin in neuropsychiatric disorders. *Front Neurosci.* 2016;9:497
228. Cardoso C, Valkanas H, Serravalle L, Ellenbogen MA. Oxytocin and social context moderate social support seeking in women during negative memory recall. *Psychoneuroendocrinology.* 2016;70:63–69
229. Shamay-Tsoory SG, Abu-Akel A. The social salience hypothesis of oxytocin. *Biol Psychiatry.* 2016;79(3):194–202
230. Bethlehem RAI, Baron-Cohen S, van Honk J, Auyeung B, Bos PA. The oxytocin paradox. *Front Behav Neurosci.* 2014;8:48
231. Chen J, Evans AN, Liu Y, Honda M, Saavedra JM, Aguilera G. Maternal deprivation in rats is associated with corticotrophin-releasing hormone (CRH) promoter hypomethylation and enhances CRH transcriptional responses to stress in adulthood. *J Neuroendocrinol.* 2012;24(7):1055–1064
232. Weaver ICG, Cervoni N, Champagne FA, et al. Epigenetic programming by maternal behavior. *Nat Neurosci.* 2004;7(8):847–854
233. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. Washington, DC: American Psychiatric Publishing; 2013
234. Koita K, Long D, Hessler D, et al. Development and implementation of a pediatric adverse childhood experiences (ACEs) and other determinants of health questionnaire in the pediatric medical home: a pilot study. *PLoS One.* 2018;13(12):e0208088
235. Wade R Jr, Cronholm PF, Fein JA, et al. Household and community-level adverse childhood experiences and adult health outcomes in a diverse urban population. *Child Abuse Negl.* 2016;52:135–145
236. Child and Adolescent Health Measurement Initiative. 2019 National Survey of Children's Health: guide to topics and questions. Data Resource Center for Child and Adolescent Health supported by the US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. 2020. Available at: https://www.childhealthdata.org/learn-about-the-nsch/topics_questions. Accessed April 21, 2021
237. National Child Traumatic Stress Network. Complex trauma. Available at: www.nctsn.org/trauma-types/complex-trauma. Accessed January 11, 2021
238. Schmid M, Petermann F, Fegert JM. Developmental trauma disorder: pros and cons of including formal criteria in the psychiatric diagnostic systems. *BMC Psychiatry.* 2013;13:3. DOI: <https://doi.org/10.1186/1471-244X-13-3>
239. Shah AN, Jerardi KE, Auger KA, Beck AF. Can hospitalization precipitate toxic stress? *Pediatrics.* 2016;137(5):e20160204
240. Rzucidlo SE, Campbell M. Beyond the physical injuries: child and parent coping with medical traumatic stress after pediatric trauma. *J Trauma Nurs.* 2009;16(3):130–135
241. National Child Traumatic Stress Network. Effects. Available at: <https://www.nctsn.org/what-is-child-trauma/trauma-types/medical-trauma/effects>. Accessed January 11, 2021
242. US Department of Health and Human Services, Administration for Children and Families. Secondary traumatic stress. Available at: <https://www.acf.hhs.gov/trauma-toolkit/secondary-traumatic-stress>. Accessed January 11, 2021
243. The National Child Traumatic Stress Network. Families and caregivers. Available at: <https://www.nctsn.org/audiences/families-and-caregivers>. Accessed January 11, 2021
244. US Department of Health and Human Services, Administration for Children and Families. Resources on trauma for caregivers and families. Available at: <https://www.childwelfare.gov/topics/responding/trauma/caregivers/>. Accessed January 11, 2021
245. American Academy of Pediatrics. Parenting After Trauma: Understanding Your Child's Needs Available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Family_Handout.pdf. Accessed June 24, 2021

246. Porges S, Lewis GF. The polyvagal hypothesis: common mechanisms mediating autonomic regulation, vocalizations and listening. In: Brudzynski SM, ed. *Handbook of Mammalian*

Vocalization: An Integrative Neuroscience Approach. New York, NY: Elsevier; 2009:255–264

247. Bethell C, Gombojav N, Solloway M, Wissow L. Adverse childhood experiences,

resilience and mindfulness-based approaches: common denominator issues for children with emotional, mental, or behavioral problems. *Child Adolesc Psychiatr Clin N Am*. 2016;25(2):139–156